Patient Information (Please Print)

Name _____ Date of Birth ____/____/____
Last First Middle

Address _____ Age _____

City _____ State _____ ZIP _____

Home # □ _____ Cell # □ _____ Cell Carrier _____

Please check preferred number for contact

Email _____

Social Security Number _____ DL # _____

Occupation _____ Employer _____

Work Address _____ Work# _____

Marital Status: Single Married Divorced Widow Child

Preferred Language: English Spanish Other _____

Spouse Information OR Policyholder Information(if not patient) Relation _____

Name _____ Date of Birth _____
Last First Middle

Occupation _____ Employer _____

Work Address _____ Work Phone _____

Social Security Number _____ Cell Phone _____

Referred By _____

Emergency Contact _____ Phone _____

Primary Care Physician _____ Phone _____

Other: _____

Preferred Pharmacy #1 _____ Phone _____

Preferred Pharmacy #2 _____ Phone _____

Primary Insurance Information

Name of Ins. _____

IPA/Medical Group _____

Phone # _____

ID# _____

Group# _____

Policyholder _____

Policyholder DOB: _____

Relationship: Self Spouse Other _____

Second Insurance Information

Name of Ins. _____

IPA/Medical Group _____

Phone# _____

ID# _____

Group # _____

Policyholder _____

Policyholder DOB: _____

Relationship: Self Spouse Other _____

_____ Initial **Release of Protected Health Care information** via telephone or answering machine or voice mail. I give my consent with authorization to the medical and billing staff of my physician's office to leave protected health care information about me or for me on my answering machine or voice mail via the telephone # I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

Home Telephone # _____ Cell phone #_____ Other # _____

Authorization of Benefits to Physician:

I hereby authorize payment directly to Ventura County Obstetric & Gynecologic Medical Group, Inc. of the surgical and/or medical benefits, if any, otherwise payable to me for the services as described on the attached claim.

Authorization to Release Information:

I hereby authorization Ventura County Obstetric & Gynecologic Medical Group, Inc. to release any information, acquired in the course of my examination of treatment, to my insurance company(s).

_____

Signature Date

Ventura County Obstetric & Gynecologic Medical Group, Inc.

Richard A. Reisman, M.D. John C. Gustafson, M.D. Steven G. Coyle, M.D
Wendy Steiger, C.N.M. Wendy Margolis, NP, M.S.N. Anne Chezar-Garnett, C.N.M.
Tax ID # 953152550
2795 Loma Vista Road
Ventura, CA 93003
805-643-8695 Fax 805-643-2087

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

_____ I hereby acknowledge that I have been informed that I may obtain the Notice of Privacy
Initials
Statement of Ventura County Obstetric and Gynecologic Medical Group, Inc.

LAB DISCLAIMER

All specimens are sent to outside laboratories. You may be responsible for additional monies for these tests. We do not know what your ultimate financial responsibility will be. We will send your specimen to the contracted lab designated by your insurance carrier for processing and they will bill accordingly.

_____ I understand that it is my responsibility to contact my insurance to determine
Initials what laboratory services are covered under my specific plan.

WELL-WOMAN AND PAP SMEAR DISCLAIMER

_____ ►Most insurance companies allow one well-woman exam/pap smear in a twelve month period.
Initials

_____ ►Your signature below signifies your acknowledgement of the benefit limitations (one exam/pap smear
Initials per twelve months).

_____ ►You are stating that, to the best of your knowledge, you have not had a well-woman
Initials exam/pap smear within the past twelve months.

_____ ►If you have already received a well-woman exam/pap smear in the past twelve month period,
Initials you will be responsible for payment of today's visit.

_____ _____ _____
Patient Name (please print) Patient Signature Date

PRENATAL FLOW RECORD

Date _____
Contact @ Home _____

Name _____Birth Date _____Age _____

Address _____Phone_____Wk Phone _____

Patient's Work Address _____Occupation _____

Husband's Name _____Occupation _____

Gynecologic History: Last Pap _____Number of Pregnancies _____

Number of Live Births _____ Miscarriages or Abortions _____ First Day of Last Menstrual Period _____ First Day of Previous Menstrual Period _____

Age of First Menstrual Cycle _____ How Often _____ Length of Cycle _____ Cramps ? Yes No

Contraceptive History _____

Medical History

___ DES Exposure
___ Genital Herpes
___ Pelvic Inflammatory Disease
___ Chicken Pox
___ German Measles
___ Measles
___ Diabetes
___ Asthma
___ Thrombophlebitis
___ Rheumatic Fever
___ Thyroid Disease
___ Hepatitis
___ Seizures
___ High Blood Pressure
___ Urinary Infections
___ Blood Transfusions
___ Heart Disease
___ Migraines
___ Cancer

Habits/Addictions
___ Coffee
___ Alcohol
___ Drugs
___ Smoker

Operations _____

Medication Allergies_____

Current Medications _____
Include all vitamins, supplements and over-the-counter medications

Family History Immediate Family _____Nationality _____

Diabetes _____Cancer _____Heart Disease _____

Twins _____ Hereditary Disorders/Congenital Anomalies _____

Husband Age _____Height _____ Weight _____ Blood Type and Rh _____

Previous Pregnancies

Name	Date	Weeks	Sex	Birth Weight	Complications of Pregnancy	Length of Labor	Complications of Labor	Anesthesia	Baby Diet	Post-partum Complications

Abortions

Date	Weeks	Spontaneous or Induced	Operation	Complications

Physical Examination

Height _____ Usual Weight _____Thyroid _____Lungs _____

Back _____Breasts _____ Nipples _____

Heart _____ Abdomen_____

PELVIC: Cervix _____Uterine Size _____Adnexae_____

Pelvimetry : Shape _____Adequacy _____

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2795 Loma Vista Road, Ventura, California, 93003
805-643-8695 Fax: 805-643-2087 www.vtaobgyn.com

Name: DOB:

Risk Factors & Problem List

1 _____

2 _____

3 _____

4 _____

Age _____

G _____ P _____ SAB _____ Tab _____ SB _____ LC_____

Allergies _____

Breast Feeding _____ Yes _____ No

LMP _____Height _____

EDC by LMP _____EDC by first Exam _____

EDC by U/S _____ Composite EDC _____

Prenatal Classes _____Instructor _____

Pediatrician _____

Spouse has met Doctor _____

Referring Doctor _____

Gender ♀ ♂ Does not want to know □

Lab Results

Hg			
Hct			
Date			

Blood Type

And Rh _____ Rhogam _____ VDRL _____

PAP _____ Rubella _____

O'Sullivan _____GTT _____

HIV _____ Hep C Ab _____

Herpes _____ Urine Culture _____

Hep B _____ GBS _____

Cx Culture _____CF _____

AFP Protocol:

Book Given _____

Decision Made _____

Blood Drawn _____

Results _____

Amniocentesis _____Date _____Result s _____

Refused □ Date _____ Initials _____

Visit																		
Weeks Gestation																		
Fetus	Fundal Height																	
	Heart Rate																	
	Movement																	
	Est. Presentation																	
WT	Pre-Gravid	This Visit																
		Cumulative																
Blood Pressure																		
Urine	Sugar																	
	Albumin																	
Edema																		
Symptoms	Bleeding																	
	Discharge/Itching																	
	Dizziness/Fainting																	
	Headache/Blurred Vision																	
	Leg Cramps																	
	Nausea/Vomiting																	
Optional	Non Stress Test																	
	Cervical Exam																	
Pregnancy Risk Level																		
Next Appointment																		
Initials																		

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Name:	DOB:
Date	**Progress Notes**

Pregnancy Risk Indicators			**Genetic Screening** **Includes Patient, Baby's Father, or Anyone in either Family with:**		
	YES	NO		YES	NO
DRUG DEPENDENCIES			PATIENT'S AGE > 35 YEARS		
HABITUAL SMOKER (MORE THAN 1 PACK A DAY)			THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ORIENTAL BACKGROUND) MCV <80		
PREGNANCY WITHOUT FAMILY OR PARTNER'S SUPPORT			NEURAL TUBE DEFECT (MENINGOMYELOCELE, OPEN SPINE OR ANENCEPHALY)		
PRIOR TRANSFUSIONS			DOWN SYNDROME		
INCOMPETENT CERVIX			TAY SACHS (E.G. JEWISH BACKGROUND)		
HABITUAL ABORTION			SICKLE CELL DISEASE OR TRAIT		
UTERINE SURGERY (NON-CESAREAN)			HEMOPHILIA		
PRIMIGRAVIDA (IF "YES" SKIP TO "DIABETES")			MUSCULAR DYSTROPHY		
CESAREAN SECTION			CYSTIC FIBROSIS		
FETAL DISTRESS			HUNTINGTON CHOREA		
NEONATAL DEATHS			MENTAL RETARDATION		
PREMATURE OR LBW INFANTS			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
CONGENITAL OR CHROMOSOMAL ANOMALIES			OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
HBW INFANTS (MORE THAN 10 POUNDS)			PATIETN OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
DIABETES			≥3 FIRST-TRIMESTER SPONTANEOUS ABORTIONS OR STILLBIRTH		
HEART DISEASE			MEDICATIONS OR STREET DRUGS SINCE LAST MENSTRUAL PERIOD IF YES, AGENT(S)		
GENITAL HERPES					
			OTHER SIGNIFICANT FAMILY HISTORY (SEE COMMENTS)		

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NOTES

Name :	DOB:

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PREECLAMPSIA QUESTIONNAIRE

VCOBGYN 2795 LOMA VISTA RD
VENTURA, CA 93003

Name: _____Date:_____

Do you have any of these ***HIGH-RISK*** factors?

Please circle Yes or No

Yes or no I had preeclampsia in a prior pregnancy.

Yes or No I am having twins, triplets, or more.

Yes or No I have high blood pressure.

Yes or No I have diabetes (type 1 or 2).

Yes or No I have kidney disease.

Yes or No I have an autoimmune disorder
(lupus, antiphospholipid disorder)

IF YOU HAVE CIRCLED Yes on one or more TALK TO YOU DOCTOR ABOUT LOW-DOSE ASPRIN TO REDUCE RISK.

Do you have any of these ***MODERATE-RISK*** factors?

Yes or No This will be my first child.

Yes or No I will be 35 years or older when my baby is born.

Yes or No I am obese [BMI is 30 or more]

Yes or No This is an IVF pregnancy.

Yes or No I am African American or have African or Afro-Caribbean ancestry.

Yes or No My mother or sister had preeclampsia during pregnancy.

Yes or No I have had a previous pregnancy and the most recent more than 10 years ago.

Yes or No I had a previous child who weighed less than 5 ½ pounds at birth.

Yes or No I have a challenging financial, social, or personal situation.

Ventura County OB/GYN Medical Grp, Inc
2795 Loma Vista RD
Ventura, CA 93003

Dear Patient,

In order for us to stay within the HIPAA guidelines, please list below anyone that you authorize us to disclose information to regarding your Protected Health Information. It is not mandatory that you list anyone. **(You do not need to list any of your doctors).**

	Name	**Relationship**
1 .	_____	_____
2 .	_____	_____
3 .	_____	_____

Do we have your permission to leave information on your **answering machine** or **voicemail** if we are unable to reach you? ____ Yes ____ No

What is the best number to contact you at: _____

_____ _____

Patients Name (Please Print) Date of Birth

_____ _____

Patient or Parent/Guardian Signature Today's Date

Ventura County OB/GYN Medical Grp. Inc.

Patient Health Questionnaire-2 (PHQ-2)

DATE:

_____Name:_____DOB_____

Instructions:
Please respond to each question.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Give all answers as 0 to 3, using this scale:
0=Not at all; 1=Several days; 2=More than half the days; 3=Nearly every day

1. **Little interest or pleasure in doing things: _____ (0-3)**
2. **Feeling down, depressed, or hopeless: _____ (0-3)**

Instructions
Clinical personnel will follow standard scoring to calculate score based on responses.

Total Score: _____

PHQ-2 score obtained by adding for each question (total points)

Interpretation:
A PHQ-2 score ranges from 0-6. The authors identified a score of 3 as the optimal cut point when using the PHQ-2 to screen for depression.

If the score is 3 or greater, major depressive order is likely.

Patients who screen positive should be further evaluated with the PHQ-9, other diagnostic instruments, or direct interview to determine whether they meet criteria of depressive disorder.

Providers Signature:
_____Date:_____

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2795 Loma Vista Road, Ventura, CA 93003 Phone: 805-643-8695 Fax: 805-643-2087

Patient Name:_____DOB:_____

PRENATAL DIAGNOSIS SCREENING QUESTIONNAIRE

1. Will you be age 35 or older when the baby is due? ___Yes___No
   ___Age When Due
2. Have you or the baby's father, or anyone in either of your families, ever had:
   a. Down syndrome or mongolism? ___Yes___No
   b. Spina bifida or meningomyelocele (open spine)? ___Yes___No
   c. Hemophilia (bleeding disorder)? ___Yes___No
   d. Muscular dystrophy? ___Yes___No
   e. Cystic fibrosis? ___Yes___No
3. Have you or the baby's father had a child born dead or alive with a birth defect not listed in #2 above? ___Yes___No

   If yes, describe:_____
4. Do you or the baby's father have any close relatives who are mentally retarded? ___Yes___No
5. Do you or the baby's father, or a close relative in either of your families, have an inherited genetic or chromosomal disorder not listed above? ___Yes___No

   If yes, describe:_____
6. Have you had two or more spontaneous pregnancy losses? ___Yes___No
7. Do you or the baby's father have any close relatives descended from Jewish people who live in Eastern Europe (Ashkenazi Jews)? ___Yes___No
8. Are you or the baby's father of African descent? ___Yes___No

   Have you or the baby's father been screened for sickle cell trait and found to be positive? ___Yes___No
9. Are you or the baby's father of Southeast Asian, Greek, Italian, or Mediterranean descent? ___Yes___No

   Have you been screened for thalassemia? ___Yes___No