Rancho OB/GYN

PERSONALIZED MEDICAL CARE FOR WOMEN

Better Health Starts Here

NEW PREGNANCY FORM

Patient's Name: _____ DOB: _____

Email Address:_____

Cell Phone: _____ Home Phone: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you, as our patient, may be used and disclosed during the course of your treatment. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Rancho OB/GYN is required by law to maintain your confidentiality except under certain circumstances. The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information
2. During a lawsuit or similar proceeding in response to a court order.
3. To a law enforcement official with a subpoena or court order
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, we will only made disclosures to a person or organization able to help prevent the threat
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities
6. To federal officials for intelligence and national security activities authorized by law
7. To correctional institutions or law enforcement while you are detained, arrested or incarcerated.
8. For Workers Compensation Lawsuits where you have filed a lawsuit.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we do not

disclose your health information to certain individuals involved in your care, such as family members and friends. However, we may be required by law to disclose the information to a third party in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of your health information, including patient medical records and billing records. You must submit your request in writing to your physician.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to your physician. You must provide us with a reason that supports your request for amendment.
5. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: Privacy Officer, 25395 Hancock Ave. Ste 210, Murrieta, CA 92562. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
6. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
7. **If you choose to have a third party present during an office visit, the discussion of any medical information will result in a waiver of your doctor-patient prvilege.**

CONSENT TO CONTACT PATIENT

Unless you notify our office in writing otherwise, Rancho OB/GYN will be contacting you from time to time at the phone number, email address, and/or home address listed in your chart. This includes calling or emailing you with lab or imaging results, sending you appointment reminders, returning phone calls and contacting you about important medical issues.

NOTICE OF E-PRESCRIPTION REQUIREMENTS

Effective January 1, 2022, all prescriptions issued by our office must be done electronically. This office complies with the e-prescription requirements of California.The benefits of issuing a prescription on line are that: It allows your doctor to see what drugs are covered by your insurance plan; Provides your doctor with a list of medcations you are already taking to avoid an adverse reaction; and allows your doctor to receive notification from the pharmacy when your prescription has been filled.

Patient Name:_____ DOB:_____

CONSENT TO DISCLOSE MEDICAL INFORMATION TO THIRD PARTY

☐ By checking this box, I permit Rancho OB/GYN to disclose my protected helath information with the persons listed below. I understnat that I may revoke my consent at any time. Revocation of any consents must be in writing.

Name_____ Relationship_____

CONSENT TO TREATMENT

1. I acknowledge that I have read and received the privacy practices from Rancho OB/GYN.
2. I understand that Rancho OB/GYN cannot guarantee the outcome of medical treatment.
3. I consent to treatment by Rancho OB/GYN.
4. If patient is a minor, I am an authorized parent or guardian of the above-referenced minor. I have legal authority to authorize Rancho OB/GYN to treat my child. I understand that California law requires the doctor to speak with my child alone and I may not be allowed to be present during the exam. I also understand that California law may prohibit the medical provider from disclosing to me any discussions the provider has with my child.

I CONSENT TO THE TERMS AND CONDITIONS IN THIS DOCUMENT:

I

Parent or Guardian Name: _____

Date: _____ Signature: _____

25395 Hancock Ave. Suite 210
Murrieta, CA 92562
www.ranchoobgyn.com
Phone: (951) 600-7066
Fax: (951) 600-7783
Email: admin@ranchoobgyn.com

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PATIENT PAYMENT AGREEMENT

Name: _____ DOB: _____

Driver's License # _____ SS#_____

Street Address: _____

City: _____ State: _____ Zip Code _____

Cell Phone: _____ Email: _____

HEALTH INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

☐ HMO ☐ PPO ☐ EPO ☐ POS ☐ HMO ☐ PPO ☐ EPO ☐ POS

Insured's Name: _____ Insured's Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

INS #: _____ INS #: _____

Primary Doctor: _____ Primary Doctor Phone# _____

EMERGENCY CONTACT

Name: _____ Phone Number: _____

PAYMENT AGREEMENT FOR SERVICES RENDERED

- I am financially responsible for all amounts owed to Rancho OB/GYN. This includes any copayments, deductibles advance deposits, and uncovered services. If I am a cash patient, I agree to pay the entire cost of the visit at time the services are rendered.
- Copayments are due at time of service. If a deductible has not been met, I will be charged an additional fee that will be applied towards the deductible. After my insurance has been billed, I will receive a letter notifying me whether I owe additional money or I am entitled to a refund. If I owe additional money, I agree to pay Rancho OB/GYN within 30 days of receipt of notice. If I am entitled to a refund Rancho OB/GYN will reimburse me the amount of the overpayment or apply the credit towards my next visit.
- I hereby authorize my insurance company to pay Rancho OB/GYN directly for any services provided to me by their office. This authorization will remain in effect until revoked in writing by the undersigned.
- There is a $50.00 cancellation fee if I make an appointment and I do not show up or I cancel within 24 hours of my scheduled appointment time.

I have read and understand the above payment agreement and I agree to be bound by its terms:

SIGNATURE: _____ DATE: _____

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PREGNANCY QUESTIONNAIRE

Patient Name:_____ **DOB:**_____

I- OBSTETRICAL HISTORY

1. Date of your last normal period_____
   a. ☐ Check the box if you are not sure of this date.
   b. Before pregnancy, were your periods regular? ☐ Yes ☐ No
   c. What type of birth control did you use before getting pregnant? _____
2. Have you been pregnant before? ☐ Yes ☐ No
   a. Number of prior pregnancies_____
   b. Number of deliveries _____
   c. Number of miscarriages _____
   d. Number of abortions _____
   e. Number of living children _____
   f. Number of C-sections _____
   g. Reason for C-section _____
3. Check the box if you experienced any of the following problems with previous pregnancies?
   ☐ Preterm labor (labor pains before the baby was due)
   ☐ Preterm delivery (more than 3 weeks before due date)
   ☐ Stillbirth (a baby born dead)
   ☐ History of a cerclage in pregnancy
   ☐ A pregnancy loss at 4-5 months
   ☐ High blood pressure, toxemia, or preeclampsia?
   ☐ Problems with the baby getting "stuck," or being hard to delivery due to large shoulders?
   ☐ Diabetes in a previous pregnancy?
   ☐ Any other problems with prior pregnancies: _____
4. Check the box if you experiencing any of the following problems during this pregnancy?
   ☐ Nausea or vomiting
   ☐ Bleeding from the vagina
   ☐ Burning or pain on urination
   ☐ Vaginal burning/itching
   ☐ Vaginal discharge (yellow or foul-smelling)
   ☐ Any other concerns: _____

II- GYNECOLOGIC HISTORY

1. At what age did your periods start? ____ years

2. Check the box if you have experienced any of the following:
   - ☐ Infertility problems
   - ☐ Abnormalities of the uterus (fibroids, double uterus, or septum, etc.)
   - ☐ Prior surgery on the female organs (removal of fibroids, surgery on the tubes, ectopic pregnancy, cone biopsy of the cervix, etc.). If yes, explain: _____
   - ☐ An abnormal pap smear, genital warts, or precancer or cancer of the cervix
   - ☐ History of STD's (herpes, syphilis, gonorrhea, chlamydia, genital warts)
   - ☐ More than one sexual partner within the past five years
   - ☐ Currently have more than one sexual partner
3. Comments: _____

III- FETAL RISK

1. Check the box if there is a family history of any of the following (include yourself, the baby's father, any other children, and anyone in either family when you answer these questions):
   - ☐ Is there a history of twins in the family?
   - ☐ Are you and the baby's father related (for example, cousins)
   - ☐ Developmental delay?
   - ☐ Downs syndrome or any other genetic defects?
   - ☐ Brain or spinal cord abnormalities: hydrocephalus, spina bifida, or meningomyelocele, etc.
   - ☐ Mouth abnormalities, such as: cleft lip or palate
   - ☐ Heart abnormalities, such as: hole in heart, abnormal valves, or other problems
   - ☐ Intestinal abnormalities: gastroschisis, omphalocele, or a baby born with intestines outside of abdomen
   - ☐ Kidney or bladder abnormalities
   - ☐ Limb defects: extra fingers, fingers stuck together, or other abnormalities of arms or legs
   - ☐ Clotting disorders, such as: hemophilia and factor 5 Leiden disorder
   - ☐ Cystic fibrosis
   - ☐ Muscular dystrophy
   - ☐ Huntington's chorea
   - ☐ Sickle cell disease or trait
   - ☐ Thalassemia (familial anemia in those of Italian, Greek, Mediterranean, or Asian background)
   - ☐ Any other genetic diseases, describe: _____
   - ☐ Are you or the baby's father Ashkenazi Jew or French Canadian?
2. Do any of the following apply during this pregnancy?
   - ☐ You are over 34 years old
   - ☐ Have had x-rays or a CT scan
   - ☐ Have taken Accutane
   - ☐ Have taken Lithium
   - ☐ Have taken Coumadin or another blood thinner (name and dose):_____
   - ☐ Have taken Seizure medicines (name and dose):_____
   - ☐ Have taken any other medicine. Please describe:_____
3. Possible environmental risks during pregnancy:
   - ☐ Check the box if you consume alcohol
     a. If yes, when did you last drink alcohol? _____
     b. How many drinks do you currently have per day? _____

☐ Check the box if you smoke or vape?

c. If yes, when did you last smoke? _____

d. How many cigarettes/vapes per day?_____

☐ Check the box if you use drugs currently or have you in the past (marijuana, cocaine, meth, etc.)?

e. If yes, when was the last time you used drugs? _____

f. Please list drugs you have used and the last time you used them:

_____

IV- MEDICAL HISTORY

1. Check the box if you have any of following medical problems?
   - ☐ Diabetes
   - ☐ History of blood transfusions
   - ☐ Thyroid disorder
   - ☐ History of blood clots or antiphospholipid disorder
   - ☐ Seizures or epilepsy
   - ☐ Bleeding disorder
   - ☐ High blood pressure
   - ☐ Low platelets
   - ☐ Heart disease
   - ☐ Lupus
   - ☐ Rheumatic fever
   - ☐ Anesthesia problems
   - ☐ Asthma
   - ☐ History of cancer
   - ☐ Kidney disease
   - ☐ History of phenylketonuria
   - ☐ Hepatitis (yellow jaundice
   - ☐ Tuberculosis

   Comments: _____

   ☐ Check the box if you have any allergies to medications?

   i. Please list them: _____

   ☐ Check the box if you've been hospitalized for any reason (other than a delivery).

   ii. State the dates and reasons: _____

   ☐ Check the box if you've had surgery for any reason other than a delivery.

   iii. State the dates and reasons: _____

2. Check the box if your baby's parents or grandparents have a history of any of the following:
   - ☐ Diabetes
   - ☐ High blood pressure
   - ☐ Heart disease
   - ☐ Cancer (describe): _____

I certify that the above information is true and accurate.

Date: _____ _____ _____

Patient Name Patient Signature

Rancho OB/GYN

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

PATIENT NAME:_____ **DOB:**_____

We would like to know how you are feeling. Please circle the answer that comes closest to how you have felt IN THE PAST 14 DAYS, not just how you feel today.

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure	☐	☐	☐	☐
7. Trouble concentrating on things, like reading or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to work, function at home, or get along with other people?

☐ Not at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

FOR OFFICE CODING _____ + _____ + _____ + _____

=Total Score: _____

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