Thank you for choosing the Medford Women's Clinic for your obstetrical care. By following the suggested guidelines below, you will help us provide you with the best care and save you time at your appointment.

Things to do before your appointment:

- ✓ Fill out the enclosed information sheets. Remember to complete both sides. Answer all questions to the best of your ability.
- ✓ Contact your health plan insurance. In some cases, **obstetrical services are not covered by health insurance.** Please ask your health plan to see if they cover "obstetrical services."
- ✓ Please check with your Primary Care Provider to be sure a **referral** is sent to us prior to your appointment if one is needed.

The day of your appointment:

- ✓ Arrive **fifteen minutes** before your scheduled appointment.
- ✓ Have your insurance card and photo ID with you.
- ✓ Have your forms completed and here with you on your visit.
- ✓ Because the initial OB appointment can be up to two hours long, please arrive on time, and make arrangements for childcare. Feel free to bring your partner or spouse.
- ✓ If you are Private Pay, payment is due on the day of service.

If you are unable to keep this appointment, please give our office **at least** a twenty-four hour notice. Should you have any questions or need assistance in completing any of the forms, please contact our office. Thank you for selecting us to help you with your health care needs.

TELEPHONE: 541.864.8900 • FACSIMILE: 541.245.3315 • E-MAIL: mwc@medfordwomensclinic.com • WEB: www.medfordwomensclinic.com
ADDRESS: 3170 State Street, Medford, OR 97504-8450

TEK 662 - 12/09

Patient Registration

Date:

LEGAL NAME:					DATE OF BIRTH:	
SOCIAL SECURITY:		MARITAL STATUS:			SEX:	
HOME PHONE:		CELL:		EMAIL:		
ADDRESS:						
RACE:	White Asian Black Pacific Islander American Indian Other:___________________					
ETHNICITY:	Hispanic or Latino Non-Hispanic or Non-Latino					
PREFERRED PHARMACY:	(name and city)					
EMPLOYER:						
OCCUPATION:			WORK PHONE:			
HAVE YOU EVER RECEIVED MEDICAL TREATMENT UNDER ANOTHER NAME? Yes No IF YES, UNDER WHAT NAME? ____						
EMERGENCY CONTACT: NAME			Phone:			
RELATIONSHIP:						

GUARANTOR (RESPONSIBLE PARTY if different from patient) OR CUSTODIAL PARENT					
NAME:		ADDRESS:			
HOME PHONE:		SS#		DATE OF BIRTH:	
EMPLOYER:				OCCUPATION:	
RELATIONSHIP:				WORKPHONE:	

PROVIDER INFORMATION	
Primary Care Physician:	
REFERRING DR:	

INSURANCE INFORMATION

I HAVE: MEDICARE MEDICAID CARD HEALTH INSURANCE NO INSURANCE
MEDICARE ID# ______________________ OREGON HEALTH PLAN ID# ______________________

Primary Insurance Information					
NAME:		ADDRESS:			
ID/POLICY #:		GROUP #:			
INSURED NAME:		DOB:		SEX:	
RELATIONSHIP TO PT:		EMPLOYER:			

Secondary Insurance Information					
NAME:		ADDRESS:			
ID/POLICY #:		GROUP #:			
INSURED NAME:		DOB:		SEX:	
RELATIONSHIP TO PT:		EMPLOYER:			

I give permission for you to share any information in my medical history with:____________________________

I authorize the medical treatment of this patient. ______________________________ Date:_______________

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents under 18, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

____ ______________________________

Patient Signature Date

____ hereby authorize ______________________________ to pay and hereby assign

(authorized signature of subscriber) (name of ins co.)

Medford Women's Clinic, LLP all benefits, if any, otherwise payable to me for my physician's services.

3170 State Street
Medford, OR 97504-8450
(541) 864-8900

Med Rec #: ______

Please fill out all below:

Name: ______

Birthdate: ______ Age ______

Phone (H) ______ (W) ______

HEALTH HISTORY (ADULT)

Date ______

Referring physician ______

Occupation (past and present) ______ PCP ______

Reason for coming to the Clinic ______

Marital Status ______ Next of Kin ______ Phone # ______

PAST MEDICAL HISTORY: Have you had any of the following problems?

Medical Illnesses

- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Cholesterol problem
- ☐ Lung disease
- ☐ Ulcers
- ☐ Brain or nerve disease (stroke)
- ☐ Liver disease or hepatitis
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Cancer ______
- ☐ Blood clots or phlebitis
- ☐ Depression/Anxiety
- ☐ Kidney disease/stones
- ☐ Acid reflux or hiatal hernia
- ☐ Migraine
- ☐ Environmental allergies
- ☐ Seizures
- ☐ Asthma
- ☐ Tuberculosis or abnormal skin test
- ☐ Osteoporosis
- ☐ Thyroid disorder
- ☐ Sexually transmitted disease
- ☐ Other ______

Operations/Hospitalizations (includes tonsillectomy and appendectomy)

Date	Operation/Hospitalization	Complications

Severe Accidents and Injuries

______

Allergies and Adverse Medication Reactions (please list reaction)

______

Tobacco Use? ☐ No ☐ Yes Pkgs/day ______ # years ______ Quit? ______ Year quit ______

Alcohol Use? ☐ No ☐ Yes Drinks/day ______ Drinks/week ______ ☐ Beer ☐ Wine ☐ Hard liquor

Have you used recreational drugs? ☐ No ☐ Yes

Date of last use? ______

Last menstrual period ______ Last pap smear ______ Last mammogram ______

Number of pregnancies ______ Number of births ______ ☐ Contraception ______

Including vasectomy ______

☐ Irregular periods ☐ Abnormal pap smear ☐ Painful periods ☐ Heavy periods Tubal ligation ______

MEDICATIONS CURRENTLY TAKEN regular or occasionally. Include vitamins, birth control pills, sleeping pills, pain pills, laxatives, aspirin – with dosage.

______

______

Glasses milk/day? ______ Last osteoporosis scan ______ Calcium supplements (mg/day)? ______

Flu shot ☐ No ☐ Yes When ______ How often do you exercise? ______

Tetanus booster ☐ No ☐ Yes When ______ What is your workout? ______

Pneumonia vaccine ☐ No ☐ Yes When ______ ______

Hepatitis B vaccine ☐ No ☐ Yes When ______ Date of last colonoscopy? ______

Gardasil vaccine ☐ No ☐ Yes When ______ Date of last endoscopy? ______

SEE REVERSE SIDE

FAMILY HISTORY

	Age of death	Age if alive	General health; major health problems & illnesses, OR age and cause of death
Mother			
Father			
Brothers			
Sisters			

Significant Illness in Grandparents, Cousins, Aunts, Uncles or Children?

____

____

Check if any of these illnesses run in the family.

	No	Yes
Osteoporosis	☐	☐
Diabetes	☐	☐
Alcoholism	☐	☐
Heart Attack	☐	☐
Stroke	☐	☐
Cancer	☐	☐
Thyroid Disease	☐	☐
Ulcers	☐	☐
Mental Illness	☐	☐
Blood Clots	☐	☐
High Blood Pressure	☐	☐
TB	☐	☐

REVIEW OF SYSTEMS: Do you have, or have had in the past month, any of the following? (Place a check mark next to those you have experienced).

General
- ☐ Recent fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Loss of energy
- ☐ Trouble sleeping

Skin
- ☐ Rashes
- ☐ Changes in mole

Blood
- ☐ Easy bruising
- ☐ Transfusions

Nose and Mouth
- ☐ Tooth pain
- ☐ Sore throat
- ☐ Sinus pain
- ☐ Nasal congestion

Breasts
- ☐ Discharge from nipples
- ☐ Lumps
- ☐ Breast pain

Cardiovascular
- ☐ Chest pain
- ☐ Leg swelling
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Varicose veins

Pulmonary
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Cough up blood

Digestive
- ☐ Poor appetite
- ☐ Gas or heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain or cramping
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Rectal bleeding

Genitourinary
- ☐ Burning on urination
- ☐ Bloody urine
- ☐ Incontinence
- ☐ Infections
- ☐ Difficulty urination
- ☐ Urination at night: # times ___________
- ☐ Multiple sexual partners

Skeletal
- ☐ Fractures
- ☐ Arthritis
- ☐ Back or neck pain

Brain and nerves
- ☐ Dizziness
- ☐ Blackouts
- ☐ Headaches
- ☐ Depression
- ☐ Anxiety, excessive worry

Is there anyone that you're afraid of?_________

Source of stress?_______________________

Do you have an Advanced Directive for end-of-life?__________________________

Medford WOMEN'S CLINIC LLP
obstetrics and gynecology

Acknowledgment and Consent for Treatment

I understand that Medford Women's Clinic (MWC) will use and disclose health information about me.

I understand that my health information may include information both created and received by MWC, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that MWC may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how MWC will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of MWC, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of MWC's Notice of Privacy Practices in effect will be posted in the waiting/ reception area.

I would like to be informed of any clinical studies that may enhance my medical treatment. I authorize my medical information, securely and confidentially, transferred to the Advanced Clinic Research department affiliated with the Medford Women's Clinic. Initial Here: ________I agree

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that MWC is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:____ Date:__________________
(Patient)

By____Date:________________
(Patient Representative)

Description of Representative's Authority:___________________________

Effective March 2009

Medford WOMEN'S CLINIC LLP
obstetrics and gynecology

Financial Policy of Medford Women's Clinic

Thank you for choosing Medford Women's Clinic (MWC). If you do not understand our financial policy please feel free to ask our patient billing representative for clarification.

- Your financial responsibility is to provide payment for services rendered.
- Come prepared to pay in full if your insurance deductible has not been met.
- It is your responsibility to provide accurate billing information, we bill your insurance as a courtesy. Should you not give us accurate information it will be your responsibility to pay in full.
- Payment options are: Cash, Check, Visa, Mastercard, Discover, American Express, and Care Credit.
- Returned checks will be subject to our bank's NSF fee. Currently this is $50.
- Should your account become delinquent a collection fee will be assessed. No-Shows will also be charged a fee.
- For patients who have made payment arrangements and the account is older than 60 days will receive a service charge of 1.5% per month (18% annual) until the account is paid in full.
- Labs and Hospital charges are billed separately and you will receive a separate statement for those costs.
- Minor children are the parent's responsibility for all services rendered.
- Pre-authorization /Second Opinions/Referrals are your responsibility. Our Billing Department will assist you in this effort.
- By signing below you are giving authority to MWC to release any information required to complete your insurance claim. This is in effect until it is revoked in writing.
- By signing below you understand this policy and are bound by it.

Email Address____________________________, Does MWC have permission to contact you through your email address?_______yes _________no

Patient or Authorized Signature____________________________ Date_______________

Print Name of Patient__________________________Date of Birth____________________

This policy is subject to change

Medford WOMEN'S CLINIC LLP
obstetrics and gynecology

3170 State Street
Medford, OR 97504-8450
(541) 864-8900

OBSTETRICAL DATABASE

GENERAL INFORMATION

Name: ____________________

Street Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Home Phone Number: ____________________ Work/Other Phone Number: ____________________

Birthdate: ____________________ Age: ____________________

Referred By: ____________________

Religion: ____________________

Marital Status: Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other: ____________________

Your Occupation: ____________________

Partner Occupation: ____________________

Education Level: 10 11 12 College 1 2 3 4 4+ Other: ____________________

Hobbies: ____________________

GYN HISTORY

Age at onset of menstruation: ____________________

Number of days between typical period: ____________________

Are you menstrual periods usually regular? Yes ❑ No ❑ If no, please explain: ____________________

____

Date of your last menstrual period? ______________

What form of contraception have you used in the past? Birth Control Pills, IUD, Diaphragm, DepoProvera, Norplant, Rhythm Method, Condoms or Abstinence.

Have you ever been treated for any sexually-transmitted diseases? Chylamydia, Gonorrhea or Herpes? ____________________

Have you ever had an IUD? If yes, date removed?: ____________________

Have you ever had an abnormal pap? If yes, please explain: ____________________

Have you ever had any surgery on your female organs? If yes, please explain and give dates: ____________________

____

Did your mother take DES when she was pregnant with you? Yes ❑ No ❑

When was the first day of your last period?: ____________________

Is this a planned pregnancy?: Yes ❑ No ❑

How tall are you?: ____________________

What is your partner's weight and height?: ____________________

Is this your partner's first baby?: ____________________

Have you had a problem with infertility in the past?: Yes ❑ No ❑ If yes, please explain: ____________________

____

Have you taken any drugs for fertility in this pregnancy?: Yes ❑ No ❑ If yes, please explain: ____________________

____

Have you had any of the following symptoms during this pregnancy that have been a significant problem for you?

Yes	No	If yes, please describe:
❑	❑	Nausea:
❑	❑	Vomiting:
❑	❑	Fatigue:
❑	❑	Burning with urination:
❑	❑	Abdominal or pelvic pain:
❑	❑	Abnormal vaginal discharge:
❑	❑	Vulvar itching or irritation:
❑	❑	Sore breasts:
❑	❑	Nipple discharge or breast lump:
❑	❑	Headaches:
❑	❑	Fever or chills:
❑	❑	Shortness of breath:
❑	❑	Irregular heartbeats:
❑	❑	Frequent indigestion, heartburn or abdominal pain:
❑	❑	Persistent cough:
❑	❑	Chest pain:
❑	❑	Unexplained weight loss:
❑	❑	Blood in stools:
❑	❑	Depression:
❑	❑	Change in a mole:
❑	❑	Urinary problems:
❑	❑	Difficulty in swallowing:
❑	❑	Leg or hand swelling:
❑	❑	Varicose veins:
❑	❑	Hemorrhoids:
❑	❑	Exposure to rubella or other viral illnesses:
❑	❑	Exposure to any drugs:
❑	❑	Prescription drugs:
❑	❑	Over-the-counter drugs:

Have you had any X-rays or other radiation exposure during this pregnancy?: Yes ❑ No ❑

If yes, please explain: ______________________________

____

MEDICAL HISTORY

Are you allergic to any drugs?: Yes ❑ No ❑ What happened?: ______________________________

Have you had any of the following?

Yes	No	If yes, please describe:
❑	❑	Serious accident or illness:
❑	❑	Pelvic or hip fracture:
❑	❑	Blood transfusion:

Have you had any of the following problems?

Yes	No	If yes, please describe:
❑	❑	Heart disease:
❑	❑	Nervous or mental problem:
❑	❑	Anesthetic complications:
❑	❑	Herpes:
❑	❑	Rheumatic fever:
❑	❑	Diabetes:
❑	❑	Tuberculosis:
❑	❑	Kidney Infection:
❑	❑	Bladder infection:
❑	❑	German measles:
❑	❑	Anemia:
❑	❑	Seizures:
❑	❑	Migraine headaches:
❑	❑	Eye problems:
❑	❑	Thyroid problems:
❑	❑	High blood pressure:
❑	❑	Breast abnormalities:
❑	❑	Asthma:
❑	❑	Ulcers:
❑	❑	Hepatitis:
❑	❑	Gallbladder disease:
❑	❑	Kidney stones:
❑	❑	Deep venous thrombosis (blood clots in your legs):
❑	❑	Bleeding abnormalities:
❑	❑	Arthritis:

HABITS

Yes	No	
❑	❑	When was the last time you had a cigarette?________ How many packs do you smoke a day? ________ How old were you when you started smoking? ____________
❑	❑	When was the last time you had a drink of alcohol?________What is the average number of drinks per week?________
❑	❑	Have you ever used street drugs?_____________ Marijuana, cocaine, crank? Have you ever put drugs in your veins? If yes, please explain:
❑	❑	Is your partner a heavy drinker?
❑	❑	Have you ever felt you ought to cut down on your drinking?
❑	❑	Have people annoyed you by criticizing your drinking?
❑	❑	Have you ever felt bad or guilty about your drinking?
❑	❑	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (eye-opener)
❑	❑	Do you use seatbelts?
❑	❑	Do you exercise regularly?

SOCIAL HISTORY

Yes	No	
❑	❑	Are there any family or social problems you feel I should know about? Explain:
❑	❑	Is your partner supportive of your pregnancy?
❑	❑	Does he plan to be present with you at your baby's birth?

FAMILY HISTORY

Do any of the following disease run in your family?

Yes	No	If yes, please describe type and relative involved:
❑	❑	Cancer:
❑	❑	Diabetes:
❑	❑	Tuberculosis:

FAMILY HISTORY (cont.)

❏ ❏ Do any of your relatives have Down's Syndrome (Mongolism) or any other chromosomal abnormalities that you know of?

❏ ❏ Are there any twins in your family?

❏ ❏ Does any member of your extended family have a cleft lip or palate, pyloric stenosis, congenital heart disease, neural tube defects (Spina Bifida or other types), clubbed feet, Cystic Fibrosis, PKU, Muscular Dystrophy, Hemophilia or any other known birth defects or abnormalities?

❏ ❏ Did any of your relatives require surgery in the first year of life?
If yes, please describe: __________

❏ ❏ Is there a family history of mental retardation?

❏ ❏ If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?

❏ ❏ If you or the baby's father are black, have either of you been screened for sickle cell trait?

❏ ❏ If you or the baby's father are Italian, Greek or Mediterranean background, have either of you been tested for β-thalassemia?

❏ ❏ If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for α-thalassemia?

❏ ❏ Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period (including nonprescription drugs)?
If yes, give name of medication and time taken during pregnancy: __________

____

PAST PREGNANCIES:

1. Please describe all your prior pregnancies, including date, live birth (yes or no), sex of child, name of child, weight of child, hospital where child was born, method of delivery (C-section or vaginal) any pre-term labor with the pregnancy and any complications during pregnancy, labor or delivery.

	First	Second	Third	Fourth	Fifth
Date					
Live birth	Yes ❏ No ❏	Yes ❏ No ❏	Yes ❏ No ❏	Yes ❏ No ❏	Yes ❏ No ❏
Sex	M ❏ F ❏	M ❏ F ❏	M ❏ F ❏	M ❏ F ❏	M ❏ F ❏
Name					
Weight					
Place of birth					
Duration of active labor					
Any complications during pregnancy, labor or delivery (please describe)					

(If more than five pregnancies, please complete on separate sheet)

Who is going to be your baby's doctor?: Pediatrician __________ Family doctor __________

Are you going to: Breast feed? ❏ Bottle feed? ❏

Is there anything about your prior pregnancy (or pregnancies), labor or delivery experiences you would or would not want repeated?: (please explain) __________

____

Is there anything else you feel your doctor should know about you, your partner or your family? __________

____