Carmel Obstetrics & Gynecology

Date:_____ Primary Language:_____

Last Name:_____ First Name:_____ M.I.____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Date of Birth_____ SSN #:_____

Home #:_____ _____Cell #_____

Email Address:_____

Employer:_____

Occupation:_____

Marital Status: (Please circle one): SINGLE MARRIED DIVORCED SEPARATED

Spouse's Name (if applicable):_____

Spouse Date of Birth:_____ Spouse Occupation:_____

Were you referred to our office? (please circle): YES NO

Referred by whom / or how did you hear about our office:_____

Emergency Contact:_____

Relationship:_____ Phone #:_____

Primary Insurance:_____HMO Group: (if applicable):_____

Primary Care Doctor:_____

Policyholder:_____

Policyholder Date of Birth:_____ Relationship:_____

Secondary Insurance (if applicable):_____

I hereby authorize Nicole J. Nguyen, M.D. to furnish my designated insurance company all information acquired in the course of my examination or treatment. I also authorize benefits under this claim to be paid directly to Nicole J. Nguyen, M.D. I understand that I am responsible for the charges not covered by this authorization & may be charged 18% annual interest on balances 90 days or more.

Signature:_____ Date:_____

Patient History

Date:_____

Name:_____

Reason for visit today:_____

PLEASE CIRCLE ANY BELOW THAT APPLY:

Family History:

DIABETES CANCER HEART DISEASE NERVOUS DISORDER BIRTH DEFECTS TWINS

Personal Past History:

IMPAIRED VISION IMPAIRED HEARING SINUS TROUBLE TONSILLITIS

CHEST PAIN SHORTNESS OF BREATH SPITTING UP BLOOD PLEURISY ASTHMA HEART TROUBLE

HIGH BLOOD PRESSURE NAUSEA VOMITTING CONSTIPATION HEMORRHOIDS JAUNDICE HEPATITIS

PAINFUL URINATION BLOOD IN URINE POOR CONTROL OF BLADDER VENEREAL DISEASE

ARTHITIS VARICOSE VEINS MUSCULAR TROUBLE BONE or JOINT TROUBLE

MIGRAINES ENDOCRINE DISORDER TUMORS or GROWTHS

Previously Married? YES or NO Infertility? YES or NO

Habits:

Tobacco: YES or NO (If YES: Packs per day:_____ Cigarettes per day or week:_____)

Alcohol: RARE OCCASIONAL NEVER Tea or Coffee: (cups per day:_____)

Menstrual History:

Length of Cycle: (How many days in between your period) _____

Length of flow: (How many days does your period last) _____

1st DAY OF YOUR LAST PERIOD:_____ Irregular Periods? YES or NO

Allergies to Medications: *(List "None" if no allergies):*_____

Pharmacy Name & Phone #:_____

Patient History Continued

Obstetrical History:

Total Number of Pregnancies (Including Miscarriage, Termination, etc.): _____

Number of children living: _____ Deceased: _____

Have you ever had a miscarriage? YES or NO

Have you ever terminated a pregnancy? YES or NO

Pregnancy #1:	Vaginal Delivery	C-Section	Termination	Miscarriage
Pregnancy #2:	Vaginal Delivery	C-Section	Termination	Miscarriage
Pregnancy #3:	Vaginal Delivery	C-Section	Termination	Miscarriage
Pregnancy #4:	Vaginal Delivery	C-Section	Termination	Miscarriage
Pregnancy #5:	Vaginal Delivery	C-Section	Termination	Miscarriage

Surgery History:

Type of Surgery: _____ _____

Age or Year Surgery Done: _____

Type of Surgery: _____ _____

Age or Year Surgery Done: _____

Type of Surgery: _____ _____

Age or Year Surgery Done: _____

Acknowledgement of Notice of Privacy Practices

We are committed to treating and using protected health information about you responsibly. This notice of privacy policies describes the personal information we collect, and how much and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice, effective 01-16-12, and applies to all protected health information as defined by federal regulations.

A copy of the Notice of Privacy Practices is available at the front desk upon request for your perusal.

Print Name:_____

Date of Birth:_____ Today's Date:_____

Signature:_____

If you would like your personal health information discussed with family members, spouse or friends please indicate their name below and relationship to you (This would include test results, billing matters and appointment information):

Name:_____

Relationship to you:_____

Name:_____

Relationship to you:_____

Name:_____

Relationship to you:_____

Signature:_____

Date:_____

A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

Our goal is to provide medical care to our patients in a way that will avoid disputes. We know that most problems occur as a result of miscommunication. So, if you have concerns about your medical care, please discuss them with us.

Please read the attached contract entitled "Physician – Patient Arbitration Agreement." By signing the contract, we are agreeing that any dispute arising out of the medical services you receive will be resolved in binding arbitration before an arbitration panel instead of by a lawsuit in a court of law.

Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

We believe that the method of resolving disputes in arbitration spares the parties some of the rigors of a court trial and the publicity which may accompany judicial proceedings.

CAP-MPT Malpractice insurance requires that all patients sign the attached arbitration agreement prior to being seen by the Physician.

Thank you.