DESERT WEST OBSTETRICS AND GYNECOLOGY

PATIENT INFORMATION

PLEASE PRINT

LAST NAME: _____ **FIRST NAME**: _____ **MI**: _____

NICKNAME: _____ **MAIDEN**: _____

BIRTHDAY: _____/_____/_____ SS#: _____

MARITAL STATUS: □ **Single** □ **Married** □ **Divorced** □ **Widowed** □ **Other:** _____

HOME ADDRESS: _____ **Apt #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

CELL #: _____ **WORK #:**_____ **EXT:** _____ **HOME #:** _____

PREFERRED DAY TIME PHONE: □ **Home** □ **Cell** □ **Work**

EMAIL: _____

PRIMARY CARE PROVIDER: _____

EMPLOYER: _____

PRIMARY INS NAME: _____ **ID/GRP#:** _____

POLICY HOLDER NAME: _____ **DOB:** _____

SECONDARY INS NAME: _____**ID/GRP#:** _____

POLICY HOLDER NAME: _____ **DOB:** _____

We are required to ask for the following information per insurance reporting requirements

RACE: □ **Alaskan Native** □ **American Indian or Alaskan Native** □ **Asian** □ **African American** □ **Caucasian** □ **Greek** □ **Hawaiian** □ **Hispanic** □ **Indian** □ **Jewish** □ **Multi-racial** □ **Native American Indian** □ **Native Hawaiian** □ **Pacific Islander** □ **Other:** _____

ETHNICITY: □ **Hispanic/Latino** □ **Not Hispanic/Latino** □ **Other** □ **Unknown** □ **I decline to specify.**

PREFERRED LANGUAGE: □ **English** □ **Spanish** □ **Other**

_____ _____

Patient / Guarantor Signature Date

_____

Guarantor Printed Name (If patient is a minor)

Desert West Payment Policy and Benefit Assignment

We are committed to providing you with quality and affordable medical care. Please review our practice financial policy.

1. **Insurance.** We participate in most insurance plans. If you are not insured or have a plan that we do not participate in, payment is expected in full at the time of your visit. It is the patient's responsibility to make sure that our office is kept informed of insurance changes. If you have questions, please contact your insurance directly.
2. **Co-payment**. All co-payments are due at the time services are rendered. For your convenience we accept Visa, MasterCard, AMEX, Discover, Care Credit, checks and cash.
3. **Non-covered Services.** Some, and perhaps all, of the services you receive may not be covered by your insurance company or may not be considered reasonable or necessary. All "non-covered" services are the responsibility of the patient.
4. **Updates.** Our staff will ask you to verify your information at each visit. Current information is vital in order for us to contact you regarding your treatment and for obtaining timely payment from your insurance company.
5. **Claims submission.** Desert West will submit your claims and assist you in any way we can to help get your claims paid. Your insurance company may need information directly from you. It is your responsibility to comply in a timely manner to their requests. Please note that the balance of your claim is your responsibility, whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company.
6. **Delinquent Accounts.** If your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full. If a balance remains unpaid, we may refer your account to an outside collection agency. If an account is reported to our collection agency a collection fee of $50 will be added to any outstanding balance. Please inform our staff if you know your payment will be late in arriving or if payment arrangements are needed.
7. **Referrals and Authorizations:** If a referral is required by your insurance carrier, you will be asked to obtain the referral prior to your appointment. If a referral is not obtained, your appointment may be cancelled. Our office will obtain any necessary authorization from your insurance carrier, prior to scheduling your appointment. We suggest you contact your insurance carrier to verify your coverage, benefits and preauthorization requirements prior to having any procedure performed. Claims are paid based on medical necessity. Please be aware that authorizations and referrals are not a guarantee of payment.
8. **Missed appointments**. You may be charged for a missed appointment (min $50), if you do not notify us at least 24 hours prior to your scheduled office visit or 7 days prior to scheduled surgery (min $100).
9. **Returned checks (NSF).** You will be charged a $50.00 processing fee for any personal check returned for non-payment.

I hereby authorize Desert West OBGYN to provide such medical services, either regular or emergency, as may be determined by my provider to be in my best interest (or the best interest of my dependent if I am signing as a parent or guardian.)

I authorize payment of medical benefits to Desert West. I agree that all charges for medical services rendered that are not directly paid by my insurance will be my responsibility. I hereby authorize Desert West to release the necessary information regarding my care to my health plan in order to complete and process my insurance claims.

Please note, all forms and policies can be found on Desert West's website at www.desertwestobgyn.com

_____ _____

Signed (patient or parent, if minor) Date

Desert West OBGYN
6678 W Thunderbird Road
Glendale, AZ 85304
602-978-1500

HIPAA FORM
AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

PATIENT NAME:_____DATE OF BIRTH:_____

I hereby Authorize Desert West OBGYN to release or disclose my medical or financial/ insurance information to:

Name:_____ Relationship:_____Phone:_____

Name:_____ Relationship:_____Phone:_____

Emergency Contact Name: _____Phone Number:_____

Yes No I grant permission to leave detailed test results or messages on my voicemail at Phone number:_____

Yes No I authorize the release of any records regarding Contraception, STD's or Substance Abuse to the person(s) listed above.

PATIENT CONTACT

We may disclose your medical information to a family member or friend who is involved in your medical care, or to someone who helps pay for your care. (For example, we may leave messages with family regarding your treatment, appointment reminders and/ or test results when you are not available.)

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

Please be advised: Any health care record can contain personal and/ or private information you may not want divulged such as STD results. HIV/AIDS testing, whether negative or positive, requires a separate form. This information may be directly generated by Desert West OBGYN doctors as part of your care or it may be indirectly generated by requesting records from other treating doctors. All medical information contained in a patient's chart is necessary for complete and accurate treatment of your condition and will be released to the person(s) named above unless it is specifically stated only certain information may be released.

By signing below I acknowledge that I am aware of Desert West's participation in the Arizona HIE and I have received, read and understand the NOTICE OF HEALTH INFORMATION PRACTICES.

By signing below I acknowledge that I am aware of Desert West's NOTICE OF PRIVACY PRACTICES.

Patient/Parent Signature_____Date_____

Print Name of Person Signing: _____

IF PATIENT IS UNDER AGE 18 - CONSENT FOR TREATMENT OF MINORS – By signing below, I hereby give my consent for medical treatment for the above-named patient. This authorization shall remain in effect until the child turns 18 or until revoked by me in writing.

Parent Signature: _____

Desert West Obstetrics and Gynecology, Ltd.
Confidential Medical History - OB

Name _____ Birthdate_____ Age _____ Date_____

Current Medications (Prescription, over the counter, herbal)	**Prescribing Doctor**	**Dose**	**Instructions**	**Reason Used**

Allergies to medications/food/environment	**Reaction**

Pharmacy: _____

Gynecologic Health History

LMP (first day of your last period): _____ Definite / Unknown date / Approximate date

Were your periods regular before pregnancy? Yes / No How often? _____

Were you on birth control at the time of conception? Yes / No Explain: _____

What age were you when you started your first period? _____

Was this a planned pregnancy? Yes / No

Was this a result of In Vitro Fertilization? Yes / No

If yes: donor sperm / donor egg

What was the date of conception? _____

Total number of pregnancies

Full Term	**Premature**	**Cesarean Section**	**Vaginal Delivery**	**Living**	**Multiple Births**	**Abortion**	**Miscarriage**	**Ectopic**

Pregnancy Details

Preg #	**Sex**	**Month/Year of Delivery**	**Number of Weeks**	**Baby's Weight**	**Hours of Labor**	**Delivery Type**	**OB/Neonatal Problems**	**Delivery Doctor**

Symptoms since your last period? _____

_____

What medications have you taken since your last period? _____

_____

Medical History

Have you had or have any of the following conditions:

Disease/Condition	Yes	No	Onset Date	Treatment
Diabetes				
Hypertension				
Heart Disease				
Autoimmune Disorder				
Kidney Disease/UTI				
Neurologic/Epilepsy				
Psychiatric				
Depression/Postpartum Depression				
Hepatitis/Liver Disease				
Varicosities/Phlebitis/ Blood Clot				
Thyroid Dysfunction				
Trauma/Violence				
History of Blood Transfusions				
Rh Sensitized				
Pulmonary (TB, Asthma)				
Seasonal Allergies				
Drug/latex allergies/ reactions				
Breast Problems				
GYN Surgery				
Operations/Hospitalization				
Anesthetic Complications				
History Abnormal Pap				
Uterine Anomaly/DES				
Infertility				
ART Treatment				
Relevant Family History				
Received HPV Vaccine				

Desert West Obstetrics and Gynecology, Ltd.
Confidential Medical History - OB

Name _____ Birthdate_____ Age _____ Date_____

Infection History

Have you ever been diagnosed with or exposed to any of the following conditions:

Condition	Yes	No	Exposure/Onset Date	Treatment
TB				
Rash/viral illness				
Hepatitis B or C				
Chicken pox				
Gonorrhea				
Chlamydia				
HPV/Warts				
HIV				
Syphilis				
Genital herpes				
Other:				

Medical/Surgical History

Include injuries and conditions requiring medications i.e. high blood pressure, diabetes, seizures, etc.

Condition/Disease	Date	Treatment

Do you desire sterilization after pregnancy? Yes / No

Will you be: breast feeding / bottle feeding / both

Family History

Please complete if any of your close relatives have had any of the following:

Disease	Yes	No	Relation	Family Member's 1st Name	Age of Onset	Age of Death	Cause of Death (Yes or No)
Cancer of Breast							
Cancer of Ovary							
Cancer of Uterus							
Cancer of Cervix							
Cancer of Colon							
Diabetes							
Tuberculosis							
Heart Disease							
High Blood Pressure							
Blood Clot/PE							
Other: (enter below)							

Social History

Marital status _____

Do you have an Advanced Directive? Yes / No

Primary language spoken _____ Race _____

Do you smoke cigarettes? Yes / No If yes, pks/day _____ How many years _____

Do you use e-cigarretes or vape? Yes / No If yes, with nicotine? Yes / No How many mg? _____ How often? _____

Do you drink alcohol? Yes / No If yes, what kind? _____ How often? _____ Amount _____

Do you consume caffeine? Yes / No If yes, what kind? _____ Amount _____

Do you use medical marijuana? Yes / No If yes, what kind? _____ How often? _____ Amount _____

Do you use recreational drugs? Yes / No If yes, what kind? _____

(We do recommend that you discontinue the use of nicotine, alcohol, caffeine, medical marijuana, and recreational drugs)

Do you exercise? Never / Occasionally / Daily / 2-3 times per week / 4 or more times per week

How many sexual partners do you have? None / 1 / 2-5 / 5+

Have you been exposed to sexual or physical violence or abuse? Yes / No

Genetic History

Includes patient, baby's father, or anyone in either family

History	Yes	No	Mother (patient)	Baby's Father	Other Relative
1. Patient's age 35 or older at delivery					
2. Thalassemia					
3. Neural tube defect					
4. Congenital heart defect					
5. Down syndrome					
6. Tay-sachs					
7. Canavan disease					
8. Familial dysautonomia					
9. Sickle cell disease or trait					
10. Hemophilia or other blood disorders					
11. Muscular dystrophy					
12. Cystic fibrosis					
13. Huntington's chorea					
14. Mental retardation/ Autism					
15. Other inherited genetic or chromosomal disorder					
16. Metabolic disorder (e.g. PKU, Type 1 diabetes)					
17. Patient or baby's father had a child with birth defects not listed above					
18. Recurrent pregnancy loss or stillbirth					
19. Medications (supplements, vitamins, herbs or OTC drug/illicit/recreational drugs/ alcohol since Last Menstrual Period?					