

# Patient Demographic Form



## Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Maiden Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_

Employment Status:  Employed  Unemployed  Retired  Student  Other Circumstance: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Other Circumstance: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity:  Hispanic or Latino  Not Hispanic or Latino

Preferred Language: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Primary Insurance Information

Name of Insurance: \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Policy Holder's D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder's S.S. #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Secondary Insurance Information (if applicable)

Name of Insurance: \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Policy Holder's D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder's S.S. #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I authorize Avina Women's Care and any entity authorized by my healthcare provider to contact me by using any telephone number, email address and mailing address provided. I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to Avina Women's Care. By signing this form, I agree to be fully responsible for payment of services deemed medically unnecessary or are not covered by my insurance carrier.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent/Guardian Signature, if applicable)

# Authorization for Use and Disclosure of Health Information



Avina Women's Care can contact me with detailed information and leave a message at

Phone #: (\_\_\_\_\_) \_\_\_\_\_ Type (cell, home, work): \_\_\_\_\_

Avina Women's Care has permission to contact and disclose my medical condition and/or treatment with

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

I understand that I may request a copy of the information used or disclosed under this authorization.

I understand that if the person or entity who receives my protected health information is not covered by Federal Health Care Privacy regulations, the personal health information disclosed may be re-disclosed to another person or entity and it will no longer be protected by Federal Health Care Privacy rules.

I understand that I may refuse to sign this authorization and that this refusal will not affect my ability to obtain health care treatment from Avina Women's Care, payment for this treatment, my ability to enroll in a health care plan or be eligible for health care plan benefits.

I understand that I have the right to revoke this authorization at any time, in writing, by notifying the Avina Women's Care Privacy Officer.

Patient Name (Printed): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent/Guardian Signature, if applicable)

# Medical History Questionnaire



Date of Visit: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Primary Care Physician: \_\_\_\_\_ Patient Type:  New Patient  Current Patient  
(seen in past 3 years)

Reason for Visit:  Annual/Preventative Exam  OB Exam  GYN Exam Problem: \_\_\_\_\_  
 Other: \_\_\_\_\_

## Pregnancy History

Number of: Pregnancies \_\_\_\_\_ Full Term Deliveries \_\_\_\_\_ Premature Deliveries \_\_\_\_\_  
Miscarriages \_\_\_\_\_ Ectopics: \_\_\_\_\_ Abortions \_\_\_\_\_ Living Children \_\_\_\_\_

1. Delivery Date (year): \_\_\_\_\_ Gender (circle): M / F Birth Weight: \_\_\_\_\_ Weeks at delivery: \_\_\_\_\_  
Delivery Type (circle): Vaginal / C-section Complications: \_\_\_\_\_

2. Delivery Date (year): \_\_\_\_\_ Gender (circle): M / F Birth Weight: \_\_\_\_\_ Weeks at delivery: \_\_\_\_\_  
Delivery Type (circle): Vaginal / C-section Complications: \_\_\_\_\_

3. Delivery Date (year): \_\_\_\_\_ Gender (circle): M / F Birth Weight: \_\_\_\_\_ Weeks at delivery: \_\_\_\_\_  
Delivery Type (circle): Vaginal / C-section Complications: \_\_\_\_\_

Additional Pregnancies: \_\_\_\_\_

## Menstrual History

Age of first menstrual period: \_\_\_\_\_ Regular monthly cycles? (circle): Yes / No / N/A

First day of last period : \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Current Method of contraception: \_\_\_\_\_

History of STDs: \_\_\_\_\_

## Preventative Care

Last Pap Smear: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Previous Abnormal Pap? (circle): Yes / No Gardasil Vaccine? (circle): Yes / No

Last Mammogram: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Where: \_\_\_\_\_ Previous Abnormal Mammo? (circle): Yes / No

Last Cholesterol Test: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last Colonoscopy: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last DEXA (Bone Density): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Current Medications (Including Over-the-Counter and Vitamins)

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

## Allergies (Drugs and/or Food)

Type: \_\_\_\_\_ Reaction: \_\_\_\_\_

Type: \_\_\_\_\_ Reaction: \_\_\_\_\_

Type: \_\_\_\_\_ Reaction: \_\_\_\_\_

## Surgeries and/or Major Injuries

Type: \_\_\_\_\_ Year: \_\_\_\_\_

Type: \_\_\_\_\_ Year: \_\_\_\_\_

Type: \_\_\_\_\_ Year: \_\_\_\_\_

## Social History

Regular Exercise? (circle): Yes / No Times per week: \_\_\_\_\_

Caffeine Intake? (circle): Yes / No Servings per day: \_\_\_\_\_ Alcohol use? (circle): Yes / No Drinks per week: \_\_\_\_\_

Tobacco Use? (circle): Yes / No If yes, describe: \_\_\_\_\_ Recreational drug use? (circle): Yes / No

## Medical History

Check box if you have a history of:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental Health Disorder      | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Mitral Valve Prolapse       | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Infertility         | <input type="checkbox"/> Neurologic Disorder         | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Ovarian Cyst                | <input type="checkbox"/> Thyroid Disease    |
| <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Lung Disease        | <input type="checkbox"/> Polycystic Ovarian Disease  | <input type="checkbox"/> Uterine Fibroids   |

## Family History

Check box and list relation (e.g. mother, father, brother, sister, etc.):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Alcoholism _____          | <input type="checkbox"/> Diabetes _____             | <input type="checkbox"/> Mental Health Disorder _____ |
| <input type="checkbox"/> Autoimmune Disorder _____ | <input type="checkbox"/> Endometrial Cancer _____   | <input type="checkbox"/> Osteoporosis _____           |
| <input type="checkbox"/> Birth Defects _____       | <input type="checkbox"/> Epilepsy _____             | <input type="checkbox"/> Ovarian Cancer _____         |
| <input type="checkbox"/> Blood Clots _____         | <input type="checkbox"/> Genetic Disorder _____     | <input type="checkbox"/> Pancreatic Cancer _____      |
| <input type="checkbox"/> Breast Cancer _____       | <input type="checkbox"/> Heart Disorder _____       | <input type="checkbox"/> Sickle Cell Disease _____    |
| <input type="checkbox"/> Cerebral Palsy _____      | <input type="checkbox"/> High Blood Pressure _____  | <input type="checkbox"/> Stroke _____                 |
| <input type="checkbox"/> Cervical Cancer _____     | <input type="checkbox"/> High Cholesterol _____     | <input type="checkbox"/> Thyroid Disease _____        |
| <input type="checkbox"/> Colon Cancer _____        | <input type="checkbox"/> Kidney Abnormalities _____ | <input type="checkbox"/> Uterine Cancer _____         |
| <input type="checkbox"/> Cystic Fibrosis _____     | <input type="checkbox"/> Liver Disease _____        | <input type="checkbox"/> Other _____                  |

## Symptoms

Check box if you have any of these symptoms:

### Reproductive & Urinary Symptoms

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abnormal Bleeding        | <input type="checkbox"/> Hot Flashes         | <input type="checkbox"/> Sexual Difficulties         |
| <input type="checkbox"/> Bleeding After Sex       | <input type="checkbox"/> Menstrual Cramps    | <input type="checkbox"/> Urinary Incontinence        |
| <input type="checkbox"/> Bleeding Between Periods | <input type="checkbox"/> Night Sweats        | <input type="checkbox"/> Urination Frequency/Urgency |
| <input type="checkbox"/> Bleeding Post-Menopause  | <input type="checkbox"/> Painful Intercourse | <input type="checkbox"/> Vaginal Discharge           |
| <input type="checkbox"/> Blood in Urine           | <input type="checkbox"/> Pelvic Pain         | <input type="checkbox"/> Vaginal Dryness             |
| <input type="checkbox"/> Burning Urination        |  |  |

### General Symptoms

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Blood in Stool          | <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Shortness of Breath  |
| <input type="checkbox"/> Breast Mass/Discharge   | <input type="checkbox"/> Fever/Chills           | <input type="checkbox"/> Swollen Legs         |
| <input type="checkbox"/> Chest Pain/Palpitations | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Varicose Veins/Clots |
| <input type="checkbox"/> Constipation            | <input type="checkbox"/> Hearing Loss           | <input type="checkbox"/> Weight Changes       |
| <input type="checkbox"/> Cough                   | <input type="checkbox"/> Jaundice/Liver Disease | <input type="checkbox"/> Wheezing             |
| <input type="checkbox"/> Depression/Anxiety      | <input type="checkbox"/> Muscle/Joint Pain      | <input type="checkbox"/> Other Symptoms _____ |
| <input type="checkbox"/> Diarrhea                | <input type="checkbox"/> Nasal Drainage         | _____   |
| <input type="checkbox"/> Dizziness/Fainting      | <input type="checkbox"/> Nausea/Vomiting        | _____   |
| <input type="checkbox"/> Easy Bruising           | <input type="checkbox"/> Numbness/Tingling      | _____   |

# Financial Policy



Thank you for choosing Avina Women's Care for your obstetric and gynecologic care. The following is a summary of our financial policy. Please take the time to understand this document and agree to our guidelines.

It is your responsibility to understand your health insurance policy, its benefits and limitations. It is a requirement of your insurance carrier that you present your insurance card at every visit. If you have any questions about your policy, please contact your agent or employer.

Our office will file your charges to your insurance carrier. It is your responsibility to pay all co-pays, deductibles, coinsurance and any balances not covered by your insurance plan(s). Co-pays and past due balances are due at the time of your appointment. If you are a self-paying patient, we also expect full payment at the time of your visit.

Self-paying maternity patients are required to establish a payment plan prior to being seen and must make an initial payment at their first obstetrical visit. The remaining delivery charges are to be paid, in full, by the 24th week of pregnancy. If you do carry insurance, you are required to pay your co-insurance or deductible (if applicable) also prior to your 24th week of pregnancy. It is your responsibility to pay all balances not included in the delivery charge, such as all laboratory work, ultrasounds and non-stress tests.

By signing this form, I acknowledge that I have read and understand the above statements.

Patient Name (Printed): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent/Guardian Signature, if applicable)

# Patient Advocacy and Mediation Program



At Avina Women's Care, it is our goal that our providers and patients engage in a cooperative approach to ensure quality healthcare. Further, our hope is that any conflicts that may arise will be resolved in the same cooperative style through mediation.

The parties to this agreement agree to pursue a good faith effort to resolve any problems that may arise between them. As a part of entering into the provider/patient relationship, the patient agrees to submit in writing to the Avina Women's Care Mediation Program, any dispute, controversy or disagreement arising out of or relating to the provider/patient relationship and the agreement to provide medical services.

1. After the matter has been presented in writing to the Avina Women's Care Mediation Program the parties will use negotiation in an attempt to reach a voluntary resolution of their differences.
2. If the dispute, controversy or disagreement is not resolved in a reasonable time, then the matter will be submitted to mediation.

The ultimate goal of mediation is to resolve any issues or concerns between the provider and patient through a neutral third party. Either party is entitled to seek legal representation at any time, but Avina Women's Care wishes to provide the patient with this opportunity to settle concerns without incurring additional costs and fees.

## Summary of Mediation:

- The patient is not required to reach a resolution in mediation.
- The mediator (or co-mediators) will be a neutral third party who is trained in mediation.
- The costs of the mediation will be paid by Avina Women's Care.
- The date, time and place of any mediation session will be scheduled by the mediator in consultation with the parties.
- The use of mediation does not preclude either party from pursuing any other remedies that may be available to them.
- Any agreements reached by the parties will be in writing and signed by both parties.
- All parties agree to make a good faith effort at mediation before pursuing litigation.
- Mediation is not a substitute for legal advice. Parties should consult with their legal counsel for any questions regarding legal rights.

By signing this form, I acknowledge that I have read and understand this Patient Advocacy Program.

Patient Name (Printed): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent/Guardian Signature, if applicable)

# Notice of Privacy Practices Acknowledgement Form



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

- I have received a copy of Avina Women's Care's Notice of Privacy Practices.
- I was offered a copy of Avina Women's Care's Notice of Privacy Practices, but declined it.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Guardian Signature, if applicable)

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## For Office Use Only:

An effort was made to provide a copy of Avina Women's Care's Notice of Privacy Practices to this patient and to obtain her acknowledgment of the same.

The patient:

- Accepted
- Declined the Notice and refused to sign this acknowledgment.

Avina Women's Care Representative Name: \_\_\_\_\_

Avina Women's Care Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Prenatal Genetics Screen



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

This form is intended to simply learn more about you and your family's history to better understand how it may influence your pregnancy. Your provider will be with you through your entire pregnancy and will answer any questions that arise along the way.

1. Will you be 35 years or older when the baby is due?  Yes  No

2. Have you, the baby's father or anyone in either of your families had any of the following? List relation (e.g. me, baby's father, relative)

- |   |   |
|---|---|
| <input type="checkbox"/> Birth Defect _____               | <input type="checkbox"/> Heart Defect _____                                   |
| <input type="checkbox"/> Canavan Dysautonomia _____       | <input type="checkbox"/> Hemophilia or Other Blood Disorders _____            |
| <input type="checkbox"/> Chromosomal Abnormality _____    | <input type="checkbox"/> Huntington's Disease _____                           |
| <input type="checkbox"/> Cystic Fibrosis _____            | <input type="checkbox"/> Muscular Dystrophy _____                             |
| <input type="checkbox"/> Developmental Disabilities _____ | <input type="checkbox"/> Neural Tube Defect (Spina Bifida, Anencephaly) _____ |
| <input type="checkbox"/> Downs Syndrome _____             | <input type="checkbox"/> Phenylketonuria (PKU) _____                          |
| <input type="checkbox"/> Familial Dysautonomia _____      | <input type="checkbox"/> Spinal Muscular Atrophy (SMA) _____                  |
| <input type="checkbox"/> Fragile X Syndrome _____         | <input type="checkbox"/> Other: _____   |

3. Indicate if the following questions apply to either you or the baby's father:

- Jewish Ancestry?  Yes  No  
    Tested for Tay-Sachs Disease?  Yes  No
- African-American?  Yes  No  
    Tested for Sickle Cell Trait?  Yes  No
- Philippine or Southwest Asian background?  Yes  No  
    Tested for A-Thalassemia?  Yes  No
- Italian, Greek or Mediterranean background?  Yes  No  
    Tested for B-Thalassemia?  Yes  No

4. Since being pregnant or since your last menstrual period, have you taken any:

- Medications, excluding iron and vitamins  Yes  No
- Recreational drugs  Yes  No

- 5. Do you have a litter box in your home?  Yes  No
- 6. Have you had chicken pox?  Yes  No
- 7. Have you had the rubella vaccine?  Yes  No
- 8. Have you had any x-rays during the pregnancy?  Yes  No
- 9. Have you been exposed to infectious diseases during the pregnancy?  Yes  No
- 10. Have you traveled outside of the country in the last three months?  Yes  No

Patient Signature: \_\_\_\_\_ Patient Name (Printed): \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Safe Medications & Vaccines in Pregnancy



## Allergies

Adhesive Nasal Strips  
Allegra  
Benadryl  
Claritin  
Flonase Allergy Relief  
Nasonex  
Saline Nasal Spray  
Singulair  
ZYRTEC

## Cold, Flu & Cough

Chloroacetic Spray  
Cough Drops / Lozenges  
Delsym  
Dextromethorphan  
Mucinex  
Robitussin  
Sudafed (2nd and 3rd Trimester)  
Tylenol Cold and Flu  
Vicks

## Constipation

Benefiber  
Citrucel  
Colace  
FiberCon  
Metamucil  
Milk of Magnesia  
MiraLAX  
Senokot

## Diarrhea

Imodium A-D  
Kaopectate  
Simethicone (Milicon or Gas-X)

## Headaches, Aches & Pains

Magnesium Oxide  
Tylenol / Acetaminophen  
*No Advil, Aspirin, Ibuprofen or Motrin*

## Heartburn, Reflux & Gas

Axid  
Maalox  
Mylanta  
NEXIUM  
PEPCID  
Prevacid  
Prilosec OTC  
Rolaids  
Simethicone (Mylicon or Gas-X)  
TUMS Antacid Chewable Tablets

## Hemorrhoids

Anusol-HC  
Preparation H  
Tucks Medicated Cooling Pads

## Insomnia

Benadryl  
TYLENOL PM  
Unisom

## Nausea & Vomiting

Dramamine  
Emetrol for Nausea & Upset Stomach  
Tigan  
Vitamin B6

## Vaginal Yeast Infection

Clotrimazole / Gyne Lotrimin  
Femstat Vaginal  
Monistat (7-Day Insert)  
Mycelex

## Vaccines

Hepatitis A  
Hepatitis B  
Influenza  
TB Skin Test  
Tetanus (Tdap)

## Prescription Medications

Albuterol Inhaler  
Amoxicillin / Ampicillin  
Augmentin  
Azithromycin / Zithromax  
Bonjesta  
Compazine  
Diclegis  
Erythromycin  
Fioricet  
Keflex  
Macrobid  
Mycolog II Cream  
Phenergan  
Lidocaine (Local Anesthetics)  
Nystatin  
Penicillin  
Prednisone  
Reglan  
Tamiflu  
Terazol  
Theo-Dur / Theophylline  
Valtex  
Ventolin

## Other

Hydrocortisone / Cortisone Cream  
Nix Lice

NOTE: If you have questions about any medications not included on this list, please talk to your provider.