DESERT BLOSSOM WOMENS CARE™

Thank you for choosing Desert Blossom Women's Care as part of your health care team! We are committed to provide the highest standard of care while keeping you at the center.

Name:	Date of Birth:	Marital Status:
SSN:	Pharmacy: Please include cross streets	
Email:	How did you hear of us?	
Current Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:
Occupation/School:		
Responsible Party Name (if minor)		
Date of Birth:	SSN:	Contact Number:
Current Address (if different):		
City:	State:	Zip Code:
Emergency Contact Name:	Contact Number:	
Primary Insurance:	Policy Holder's Name:	
Insurance Address:	Relationship to Client:	
City:	State:	Zip Code:
Policy Number:	Group Number:	Phone Number:
Secondary Insurance:	Policy Holder's Name:	
Insurance Address:	Relationship to Client:	
City:	State:	Zip Code:
Policy Number:	Group Number:	Phone Number:
Signature: (Client/responsible party if minor)		
Date:		

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HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name:	DOB:	Primary Care MD:
Reason for visit:		Date of last annual:

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Dates of Immunizations		
	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis B	☐ Chickenpox
	☐ Influenza	☐ MMR (measles, mumps, rubella)

MEDICAL PROBLEMS/DIAGNOSES BY OTHER PROVIDERS:

Year	Condition	Year	Condition

PAST MEDICAL HISTORY Please check if you have or have had any symptoms fo the following:

☐ Heart Disease	☐ Deep Vein Thrombosis/ Pulmonary embolism	☐ Breast disease	☐ Bleeding/clotting disorder
☐ Hypertension	☐ Thyroid dysfunction	☐ Anesthesia complications	☐ Osteoporosis/osteopenia
☐ Autoimmune disorder	☐ Trauma	☐ Uterine anomalies	☐ GI disease
☐ Kidney disease/frequent UTIs	☐ Blood transfusion	☐ Infertility	☐ Infectious disease
☐ Neurologic disorder/epilepsy	☐ Pulmonary disease (asthma)	☐ Diabetes	☐ Cancer
☐ Hepatitis/liver disease	☐ Seasonal allergies	☐ Anemia	☐ Other

Please list any drug allergies and reaction_____

Please list medications taking:

Medication Name	Dose/Strength	How often medication taken	

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HEALTH HISTORY continued…

PREGNANCY HISTORY

Date	Weeks	Vaginal/Cesarean Miscarriage/Termination	Sex	Name	Weight	Complications

SURGICAL/HOSPITLIZATION HISTORY (other than births)

Year	Surgery	Reason	Hospital

GYNECOLOGIC HISTORY

Age of first period	First day of last period	Period every_____days
Period lasts_____ days	Painful periods?	Recent changes?
Period flow Small Moderate Heavy Clots (Circle one)		

Have you **ever** had: ☐ D&C, year_____ ☐ Mammogram, year_____

☐ STI (please list year, type, and if treated)

☐ Abnormal pap (please list year, diagnosis, type)

_____ _____

_____ _____

_____ _____

_____ _____

Are you **currently** experiencing:

☐ Blood in urine ☐ Loss of urinary control/incontinence ☐ Blood in urine

☐ Painful urination ☐ Hot flashes/night sweats ☐ Hormonal imbalance

☐ Breast tenderness ☐ Breast lump ☐ Nipple discharge

☐ PMS symptoms (please circle) tension bloating irritability depression other

FAMILY HISTORY

	Living/Age	Deceased/ Age of death	Current Condition(s) OR Cause of Death
Father			
Mother			
Sibling(s)	☐ M ☐ F Age:		
	☐ M ☐ F Age:		
	☐ M ☐ F Age:		
	☐ M ☐ F Age:		
Children	☐ M ☐ F Age:		
	☐ M ☐ F Age:		
	☐ M ☐ F Age:		
	☐ M ☐ F Age:		
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

MENTAL HEALTH

☐ Stress is a major problem?	☐ Ever attempted suicide?
☐ Feeling depressed?	☐ Ever seriously thought about hurting yourself?
☐ History of postpartum depression/anxiety?	☐ Trouble sleeping?
☐ Feeling anxious?	☐ Ever seen a counselor?
☐ Cry frequently?	☐ Currently under counselor/psychiatric care?
☐ Eating disorder?	☐ Other concerns:

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HEALTH HISTORY continued…

SOCIAL HISTORY

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise
	☐ Occasional vigorous exercise (i.e. work/recreational less than 4x/week for 30 min)
	☐ Regular vigorous exercise (i.e. work/recreational 4x/week or more for 30 min)
Diet	☐ Special Diet (please describe, i.e. vegan, gluten free, etc.)
	☐ History of an eating disorder
Caffeine	Type of caffeine (please circle all consumed) None Coffee Tea Cola
	Number of servings (cups/cans) per day
Alcohol	If you have consumed alcohol in the **last year** please answer the following:
	How often do you consume alcohol? ☐ monthly ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week
	Number of drinks per occasion? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more
	In the last year how often have you consumed 6 or more drinks per occasion? ☐ never ☐ less than monthly ☐ monthly ☐ weekly ☐ almost daily
Tobacco	☐ Never used tobacco
	☐ Former tobacco user Year quit_____ Total number of years tobacco use_____
	☐ Current tobacco user Age started_____ How often tobacco used_____
	☐ Live with smokers?
Drugs	☐ In the last year have used recreational/street drugs
	☐ Ever used IV drugs and/or had a partner who used IV drugs
Sex	☐ Sexually active with ☐ men ☐ women ☐ both ☐ monogamous ☐ dating
	☐ Trying to conceive/become pregnant
	☐ Current contraception
	☐ Discomfort with intercourse
	Do you ☐ rent ☐ own ☐ homeless
Personal Safety	Who do you live with? _____
	Who do you depend on for support?_____
	☐ Frequent falls
	☐ Vision/hearing loss
	☐ Do not always use seatbelt
	☐ Do you have smoke detector?
	☐ Ever been physically, verbally, sexually, and/or mentally abused
	☐ I do not feel safe from physical, verbal, sexual, and mental abuse

Please feel free to write any other information you'd like to share with your healthcare team:

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NOTICE OF PRIVACY PRACTICES

Effective February 16, 2015

"This notice describes how medical information about you may be used and disclosed and how you can get access to this information, please review it carefully."

Desert Confidentiality Practices: Blossom Women's Care (DBWC) is committed to protecting your health information. This notice explains how DBWC will use, share, and protect your health information. It also explains your rights to privacy of your health information as required by law.

Uses, Sharing, and Protection of Health Information: The law only allows our staff to use your health information when doing their jobs or to share your information when it is necessary to operate our business. When health information is shared with other agencies or organizations, DBWC requires them to keep your health information confidential, which is required by state law and HIPAA. Your health information will be shared to approve or deny treatment, and to determine if you are getting the right medical treatment. For example, doctors and nurses may review the treatment plan created for you by us to make sure that the care you receive is medically necessary.

We Will Use and Share Your Health Information Without Authorization to:

~collect payments for medical services provided to you.
~coordinate payment for your care between DBWC, other health plans, and other insurance companies that may be responsible for the cost of your care.
~coordinate your care between DBWC, other health plans, and health care providers to improve the quality of your health care.
~share information with other government agencies or organizations that provide benefits or services when the information is necessary in order for you to receive those benefits or services.

We May Disclose Your Health Information Without Authorization to:

~public health agencies for activities such as disease control and prevention, problems with medical products or medications.
~health oversight agencies such as the U.S. Department of Health and Human Services and its Office of Civil Rights.
~coroners, medical examiners, and funeral directors so they can carry out their jobs as required by law.
~organizations involved with organ donation and transplantation, communicable disease and cancer registries.
~prevent a serious threat to a person's or the public's health and safety.
~military if you are or have been a member of the armed services.
~correctional facilities or law enforcement officials to maintain the health, safety, and security of the corrections systems, if you are held in custody.
~worker's compensation programs that provide benefits for work-related injuries or illness without regard to fault.
~law enforcement or national security and intelligence agencies, and to protect the President and others as required by law.
~courts of law in court cases or judicial and administrative hearings when required by law.
~if you are the victim of abuse, neglect, or domestic violence.

(Healthcare rules and laws at the state and federal level are always evolving and changing. DBWC will always assert your privacy as our highest concern and only use and share your health information as required by state and federal law.)

I acknowledge that I have received a copy or have read the office's Notice of Privacy Practices.

_____ _____

Patient or authorized individual signature Date

_____ _____

Print name if signed on behalf of patient Relationship

DESERT BLOSSOM WOMENS CARE™

FINACIAL POLICY

"WE RECEIVE MANY QUESTIONS FROM OUR PATIENTS CONCERNING BILLING AND INSURANCE COVERAGE. WE HOPE THIS FINANCIAL POLICY WILL OFFER SOME ADDITIONAL UNDERSTANDING FOR YOU."

ALL OFFICE CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. PLEASE LET US KNOW IMMEDIATELY IF YOU HAVE A FINANCIAL QUESTION OR PROBLEM BECAUSE WE DO NOT WISH TO CAUSE EMBARRASSMENT OR HARDSHIP FOR ANY PATIENTS.

WE ACCEPT CASH, CHECKS, CREDIT CARDS, & MONEY ORDERS FOR ALL TYPES OF PAYMENTS. ALL SELF-PAY (NO INSURANCE) PATIENTS ARE REQUIRED TO PAY IN FULL FOR EACH VISIT AT THE TIME OF VISIT. SELF PAYS RECEIVE A 10% CASH DISCOUNT FOR ACCOUNTS PAID IN FULL. IF PAYMENT CANNOT BE MADE AT THE TIME OF YOUR VISIT, WE MAY RESCHEDULE YOUR APPOINTMENT.

ALL INSURANCE HAS PATIENT COST-SHARING REQUIREMENTS. THEY ARE CALLED DEDUCTIBLES AND CO-PAYMENTS. NO INSURANCE COVERS EVERYTHING OR "100%." THERE ARE ALWAYS LIMITATIONS AND EXCLUSIONS TO COVERAGE. PLEASE CONTACT YOUR HEALTH PLAN IF YOU ARE UNSURE ABOUT WHAT IS COVERED OR NOT COVERED.

AS COURTESY TO OUR PATIENTS, WE BILL THE HEALTH PLAN FOR YOU AND ACCEPT ASSIGNMENT. "ASSIGNMENT" SIMPLY MEANS THE PATIENT REQUESTS INSURANCE PAYMENT BE MADE DIRECTLY TO THE PROVIDER. THIS IS NOT PAYMENT IN FULL. THE PATIENT IS RESPONSIBLE FOR THE DESIGNATED BALANCE.

MANY INSURANCE PLANS DESIGNATE 80% COVERAGE. REMEMBER, THE 80% COVERAGE IS ON AN AMOUNT SET BY THE INSURANCE PLAN, THIS IS SET LIMITATION. THE PATIENT PORTION OF PAYMENT WILL BE WHATEVER INSURANCE DOES NOT COVER.

A MISSED APPOINTMENT FEE OF $25.00 WILL BE CHARGED IF AN APPOINTMENT IS NOT CANCELLED WITHIN 24 HOURS OF A SCHEDULED APPOINTMENT. 3 CONSECUTIVE "NO SHOWS" WILL RESULT IN A DISCHARGE OF CARE.

IF YOUR HEALTH PLAN HAS NOT PAID YOUR CLAIM WITHIN 45 DAYS, YOU MAY BE BILLED. THANK YOU FOR YOUR COOPERATION.

RESPONSIBLE PARTY_____ DATE_____

PATIENT_____ DOB_____