



**New Patient History**

**I. Identifying Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Age: \_\_\_\_\_ Name of Family Doctor \_\_\_\_\_

**II. Medical History**  None

Please list any medical problems that you have.

Have you ever had:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Alcohol abuse            | <input type="checkbox"/> Anesthetic reaction         | <input type="checkbox"/> Bleeding disorder            |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Chronic lung condition       |
| <input type="checkbox"/> Blood clots              | <input type="checkbox"/> Drug and/or substance abuse | <input type="checkbox"/> Depression/anxiety           |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Heart disease               | <input type="checkbox"/> High blood pressure          |
| <input type="checkbox"/> High cholesterol         | <input type="checkbox"/> Hepatitis/Jaundice          | <input type="checkbox"/> Lupus or autoimmune disorder |
| <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Kidney stones               | <input type="checkbox"/> Hypothyroidism               |
| <input type="checkbox"/> Seizure disorder         | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Stomach ulcers           | <input type="checkbox"/> Mitral valve prolapse       | <input type="checkbox"/> Rheumatic fever              |
| <input type="checkbox"/> Transfusion reaction     | <input type="checkbox"/> Eating disorder             | <input type="checkbox"/> Cancer                       |

**III. MEDICATIONS**

List all medications that you take (with the strength & frequency)  None

<b>Drug</b>	<b>Dose</b>	<b>Frequency</b>	<b>Reason for medication</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Allergies:**  None

**IV. Surgical History**  None

List all surgeries you have had:

<b>Date</b>	<b>Operation</b>	<b>Diagnosis</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**V. General Health**

Do you drink alcohol?  No  Yes  
Do you smoke?  No  Yes How much? \_\_\_\_\_  
Do you use recreational drugs or street drugs?  No  Yes Type \_\_\_\_\_

**VI. Gynecologic History**

Date of last Pap Smear:  None \_\_\_\_\_  
Date of last mammogram:  None \_\_\_\_\_  
What was the **FIRST** day of your last menstrual period?: \_\_\_\_\_  Menopausal  Hysterectomy  
Is your period  Regular  Irregular How many days does it last? \_\_\_\_\_ Days  
Is your flow  Heavy  Moderate  Light  
What do you use to keep from getting pregnant?  
 Nothing  Vasectomy  Condoms  Rhythm  IUD  
 Tubal ligation  Diaphragm  Birth Control Pills/Patch  Abstinence  Withdrawal

**VII. Urologic History: (Complete if indicated)**  None

Do you have trouble with urine leakage?  Yes  No  
Do you leak urine when coughing, sneezing, laughing, exercising or lifting?  Yes  No  
Do you feel an urgency to urinate just before leaking urine?  Yes  No  
Do you have to wear a pad to protect against urine loss?  Yes  No

**VIII. Pregnancy history:**  No pregnancies

How many times have you been pregnant? \_\_\_\_\_ How many live births? \_\_\_\_\_ How many miscarriages? \_\_\_\_\_  
How many Ectopic Pregnancies? \_\_\_\_\_

**IX. FAMILY HISTORY:**  Adopted

Have you or any family members ever had:

Breast cancer: \_\_\_\_\_ Asthma: \_\_\_\_\_  
Ovarian cancer: \_\_\_\_\_ Stroke: \_\_\_\_\_  
Colon cancer: \_\_\_\_\_ High cholesterol: \_\_\_\_\_  
Other cancers: \_\_\_\_\_ Bleeding disorders: \_\_\_\_\_  
Diabetes: \_\_\_\_\_ Heart Disease: \_\_\_\_\_  
High Blood Pressure: \_\_\_\_\_ Anesthesia Problems: \_\_\_\_\_

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

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Helen H.T. Luong, M.D., F.A.C.O.G.*  
*Jane K. Hong, M.D., F.A.C.O.G.*  
*Women's Care OB/GYN Medical Group, Inc.*

## FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. All patients must complete the Patient Information and Health History form before seeing the Doctor.

### WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DISCOVER

We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. **It is your responsibility to know your benefits and how they will apply to your treatment by the Doctor.** We are not a party to that contract. If your insurance company has not paid your account in full within 60 days of the date of service, the balance will be transferred to you and/or the guarantor listed on the Patient Information form.

**HMO Plans** (with which we are contracted): **All co-pays must be satisfied at every visit.** Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collecting co-pays at every visit. Co-pays not paid at the time of the visit will be subject to a \$15 Administrative Fee to cover the cost of billing you.

**PPO Plans** (with which we are contracted): We have agreed to take a discount from your insurance company. Your co-insurance and co-pay are your responsibility and are due at the time of treatment. In the event your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible and/or coinsurance amounts. As a courtesy, we will bill a secondary insurance for any balance not covered by your primary insurance; however, you are responsible for the balance regardless of payment from a secondary insurance. We will not bill a third insurance. Co-pays not paid at the time of the visit will be subject to a \$15 Administrative Fee to cover the cost of billing you.

**Medicare:** We accept assignment with Medicare. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. As a courtesy, we will bill your secondary insurance for the remaining 20% of the Medicare allowed payment, however, you are responsible for the balance regardless of payment from a secondary insurance. We will not bill a third insurance.

**Usual and Customary Rates:** Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**Cash Patients:** All services must be paid in full at the time of treatment.

**Returned Checks:** A \$25.00 fee will be charged for any returned checks, regardless of the reason. We will be unable to accept your check for any services thereafter.

**Collection Accounts:** If your account is referred to our collection agency, and you wish to continue as our patient, all future services will be rendered on a cash basis. We will bill your insurance as a courtesy to reimburse you.

**OB Care and Surgery Deposits:** **If you are an OB patient, your deductible and any coinsurance amounts are required to be paid in full by your 28<sup>th</sup> week of pregnancy.** At your second OB visit, we will let you know the full amount for which you are responsible, and the date by which this amount must be paid. We will make payment arrangements with you for monthly and/or weekly payments; however, we cannot extend your payments past your 28<sup>th</sup> week of pregnancy.

If you are scheduled for a surgical procedure, you will be required to pay any out-of-pocket expenses, which are deemed the patient responsibility by your insurance carrier. This may include your deductible and any coinsurance amounts. **The patient share amount must be paid in full before your surgery is done**

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. You can reach us at (714)535-8900.

I have read the Financial Policy for Women's Care OB/GYN Medical Group, Inc. I understand and agree to this policy.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

*Helen H.T. Luong, M.D., F.A.C.O.G.*

*Jane K. Hong, M.D., F.A.C.O.G.*

*Women's Care OB/GYN Medical Group, Inc.*

**PATIENT CONSENT FOR USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

With my consent, Women's Care OB/GYN Medical Group, Inc. and its Affiliated Providers may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO.) Please refer to Women's Care OB/GYN Medical Group, Inc. and its Affiliated Provider's *Notice of Privacy Practices* for a more complete description of such uses and disclosures.

I have the right to review the *Notice of Privacy Practices* at any time. A revised *Notice of Privacy Practices* MAY BE OBTAINED BY FORWARDING A WRITTEN REQUEST TO: Women's Care OB/GYN Medical Group, Inc. 1174 N. Euclid Street, Anaheim, CA 92801

With my consent, Women's Care OB/GYN Medical Group, Inc and its Affiliated Providers may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, Women's Care OB/GYN Medical Group, Inc. and its Affiliated Providers may mail to my home, or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked "Personal and Confidential."

With my consent, Women's Care OB/GYN Medical Group, Inc. and its Affiliated Providers may email to my home or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Women's Care OB/GYN medical Group, Inc. and its Affiliated Providers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Women's Care OB/GYN Medical Group, Inc. and its Affiliated Providers' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Women's Care OB/GYN Medical Group, Inc., and its Affiliated Providers may decline to provide treatment to me.

I acknowledge that I have received a copy of the Women's Care OB/GYN Medical Group, Inc. Privacy Policies.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name Of Patient Or Legal Guardian