Magnolia Plaza

299 W. Foothill #209
Upland, CA 91786

Ph: (909) 982-4000
Fax: (909) 981-7800

Dear_____ Date_____

Welcome to Women's View Medical Group

Your appointment date is:_____.

Make note of the following:

- **Arrive 15 minutes early to your appointment**
- **Bring Insurance Card**
- **Current photo ID**
- **Co-Pay (if it applies)**
- **New patient packet needs to be filled out to its entirety; otherwise your appointment will be rescheduled.**
- **Be prepared to have your picture taken upon arrival**

We do not accept check, only Credit Card/Debit/Cash

There will be a $25.00 cancellation fee if not cancelled within 24 hours.

PATIENT INFORMATION SHEET

PERSONAL INFORMATION

Patient Name:_____ Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:( )_____ Can we leave a message _____Yes ____ No

Cell Phone:( )_____ Can We leave a Message_____Yes _____No

Birth Date:_____ Sex: M F Maritial Status *S M W D* Race:_____
Ethnicity:_____ Language:_____

Do you have an Advance Directive: Yes_____ No_____

Would you like to sign up for our Patient Portal to view your visit: Yes___ No___e-mail address:_____

EMERGENCY CONTACT

Spouse's Name:_____ Phone Number:_____

Closest Relative:_____ Relationship:_____ Phone Number:_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Name:_____ ID Number:_____

Insured's Name:_____ Relationship:_____ Birth Date:_____

SECONDARY INSURANCE

Insurance Name:_____ ID Number:_____

Insured's Name:_____ Relationship:_____ Birth Date:_____

I understand that if the above is not true, or if I am ineligible under the terms of my health plan and/or employer's group's Medical and Hospital Subscriber Agreement, I am financially responsible for all charges for services rendered.

_____

Signature Date

HEALTH QUESTIONNAIRE

NAME _____ AGE _____ DATE _____

ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Have you had

Childhood

Measles	No	Yes	Rheumatic fever or heart disease	No	Yes
Mumps	No	Yes	Tuberculosis	No	Yes
Chickenpox	No	Yes	Venereal disease	No	Yes
Diabetes	No	Yes	Congenital Abnormalities	No	Yes
Strokes	No	Yes	Other serious diseases	No	Yes
Cancer	No	Yes	_____		

Adult:

Have you had a serious illness? ..... No Yes

Have you ever been hospitalized or been under medical care for very long? ..... No Yes

If yes, for what reason? _____

Operations:

Have you had any surgery? ..... No Yes

_____ _____

_____ _____

Injuries:

Have you had any broken bones? ..... No Yes

Have you had any head concussions or injuries? ..... No Yes

Have you ever been knocked unconscious? ..... No Yes

FAMILY HISTORY:	If Living: Age	If Living: Health	If Deceased Age (at death) & Cause		Has any blood relative ever had?			
Father					Cancer	Yes	Who	What type
Mother					Tuberculosis	Yes	Who	What type
Brother/Sister					Diabetes	Yes	Who	What type
					Heart Trouble	Yes	Who	What type
					High Blood Pressure	Yes	Who	What type
Husband/Wife					Stroke	Yes	Who	What type
Son/Daughter					Convulsions	Yes	Who	What type
					Suicide	Yes	Who	What type
					Insanity	Yes	Who	What type
					Bleeding tendency	Yes	Who	What type
					Gout or other arthritis	Yes	Who	What type

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed

Are you living with your husband or wife? ..... No Yes

Is your sex life satisfactory? ..... No Yes

Do you have dependents at home? ..... No Yes

Alcoholic Beverages: ___Never ___ Rarely _____ Moderately _____ Daily _____ Ever ..... No Yes

Tobacco: _____ Cigarettes _____ Packs a day _____ Don't Smoke _____ Ever Smoked ..... No Yes

Are you employed? _____ Full time _____ Part time

What is your job? _____

Are you exposed to fumes, dust or solvents? _____

Education (Years)

Grade School _____

High School _____

College _____

Postgraduate _____

How much time have you lost from work because of your health during the past?

Six Month _____

One Year _____

Five Years _____

SYSTEMIC REVIEW: Do you have any of the following?

General:

Recent weight change ..... No Yes

Have you been in good general health most of your life No Yes

Skin:

Skin Disease ..... No Yes

Jaundice ..... No Yes

Hives, eczema or rash ..... No Yes

Frequent infection or boils ..... No Yes

Abnormal pigmentation ..... No Yes

Head-Eyes-Ears-Nose-Throat

Eye disease or injury ..... No Yes

Do you wear glasses? ..... No Yes

Double vision ..... No Yes

Headaches ..... No Yes

Glaucoma ..... No Yes

Itching eyes or nose ..... No Yes

Head-Eyes-Ears-Nose-Throat (cont'd)

Sneezing or runny nose ..... No Yes

Nose Bleeds ..... No Yes

Chronic sinus trouble ..... No Yes

Ear Disease ..... No Yes

Impaired Hearing ..... No Yes

Dizziness or transient episodes or unconsciousness ..... No Yes

Neck:

Stiffness ..... No Yes

Thyroid trouble ..... No Yes

Enlarged glands ..... No Yes

Respiratory

URI (cold) now ..... No Yes

Spitting up blood ..... No Yes

Chronic or frequent cough ..... No Yes

SYSTEMIC REVIEW:

Respiratory Cont'd
- Asthma or Wheezing ..... No Yes
- Difficulty breathing ..... No Yes
- Any trouble with lungs ..... No Yes
- Pleurisy or Pneumonia ..... No Yes

Cardiovascular:
- Chest pain or angina pectoris ..... No Yes
- Shortness of breath with walking or lying down ..... No Yes
- Difficulty walking two blocks ..... No Yes
- Heart Trouble or heart attacks ..... No Yes
- High blood pressure ..... No Yes
- Swelling of hands, feet or ankles ..... No Yes
- Awakening in the night smothering ..... No Yes
- Heart murmur ..... No Yes

Gastrointestinal:
- Peptic Ulcer (stomach or duodenal) ..... No Yes
- Vomiting blood or food ..... No Yes
- Gallbladder disease ..... No Yes
- Liver trouble ..... No Yes
- Hepatitis ..... No Yes
- Painful bowel movements ..... No Yes
- Bleeding with bowel movements ..... No Yes
- Black stools ..... No Yes
- Hemorrhoids or piles ..... No Yes
- Recent change in bowel habits ..... No Yes
- Frequent diarrhea ..... No Yes
- Heartburn or indigestion ..... No Yes
- Cramping or pain in the abdomen ..... No Yes
- Does food stick in throat ..... No Yes

Genitourinary:
- Loss of urine ..... No Yes
- Frequent urination ..... No Yes
- Night time urination ..... No Yes
- Burning or painful urination ..... No Yes
- Blood in urine ..... No Yes
- Kidney trouble ..... No Yes
- Kidney stones ..... No Yes

Gynecological:
- Age periods started _____
- How long do periods last? _____ Days

Gynecological (Cont'd)
- Number of pregnancies ..... No Yes
- Number of miscarriages ..... No Yes
- Date of last cancer smear and results _____
- Frequency of periods, every _____ days.
- Any pain with your periods ..... No Yes
- Number of children _____ Ages _____
- Date of first day of last period _____

Locomotor-Musculoskeletal:
- Varicose Veins ..... No Yes
- Weakness of muscles or joints ..... No Yes
- Any difficulty in walking ..... No Yes
- Any pain in calves or buttocks on walking relieved by rest ..... No Yes

Neuro-Psychiatric:
- Have you ever had psychiatric care? ..... No Yes
- Have you been advised to see a psychiatrist? ..... No Yes
- Do you ever have, or have had, fainting spells? ..... No Yes
- Convulsions ..... No Yes
- Paralysis ..... No Yes

Hematologic:
- Are you slow to heal after cuts ..... No Yes
- Blood disease ..... No Yes
- Anemia ..... No Yes
- Phlebitis ..... No Yes
- Have you had difficulty with bleeding excessively after tooth extraction or surgery? ..... No Yes
- Have you had abnormal bruising or bleeding? ..... No Yes

Allergic:
- Any allergies, including medication ..... No Yes

Endocrine:
- Thyroid disease ..... No Yes
- Hormone therapy ..... No Yes
- Any change in hat or glove size ..... No Yes
- Any change in hair growth ..... No Yes
- Have you become colder than before- or skin become drier ..... No Yes

HEIGHT _____
WEIGHT _____
Date of last tetanus _____

ALLERGIES AND SENSITIVITIES

1. Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administration of:

	Circle One			What Drug or Food?
Penicillin or other antibiotics	Yes	No	Don't know	_____
Morphine, Codeine, Dermerol or other narcotics	Yes	No	Don't know	_____
Aspirin, emiprin or other pain remedies	Yes	No	Don't know	_____
Sulfa drugs	Yes	No	Don't know	_____
Tetanus antitoxin or other serums	Yes	No	Don't know	_____
Adhesive tape	Yes	No	Don't know	_____
Iodine or merthiolate	Yes	No	Don't know	_____
Any other drug or medication	Yes	No	Don't know	_____
Any foods, such as egg, milk or chocolate	Yes	No	Don't know	_____

2. Drugs Recently Taken: Within the past six months has patient taken

Cortisone	Yes	No	Don't know
ACTH	Yes	No	Don't know
Anticoagulants	Yes	No	Don't know
Tranquilizers	Yes	No	Don't know
Hypotensives (high blood pressure medicines)	Yes	No	Don't know
Has the patient ever received treatment for:			
Asthma, rheumatism or rheumatic fever?	Yes	No	Don't know
Aspirin	Yes	No	Don't know

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

_____ Doctor:

_____ Date:

_____ Signature of Patient:

RX History Consent

WOMEN'S VIEW MEDICAL GROUP

Date_____

By signing below I authorize Women's View Medical Group to

obtain my pharmaceutical history through electronic medical records.

_____

Signature

AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A: Must be completed for all authorizations.

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name: _____ Date of Birth: _____

Person(s)/organizations authorized to use/disclose information (from): _____

Person(s)/organizations authorized to receive the information: _____

Women's View Medical Group
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Upland, CA 91786

Information that may be used/disclosed:
(Include dates where appropriate, e.g., medications dispensed in December 2002 or EKG Report performed in June 2000)

- ❑ Record of Visits (all) _____
- ❑ Record of Visit(s) (Specific) _____
- ❑ Discharge Summary _____
- ❑ History/Physical _____
- ❑ Consultation Report(s) _____
- ❑ Operative Report(s) _____
- ❑ Problem List _____
- ❑ Progress Notes _____
- ❑ Immunization Record(s) _____
- ❑ Medication Record(s) _____
- ❑ Laboratory Report(s) _____
- ❑ X-Ray, MRI, CT _____
- ❑ Echo, Stress Tests, Holters _____
- ❑ EKG Report _____
- ❑ Mental Health/Alcohol/Drug Abuse Treatment _____
- ❑ AIDS or HIV Information _____
- ❑ Hepatitis Information _____
- ❑ Entire Medical Record _____
- ❑ Statement of Charges/Payments _____
- ❑ Other _____

SECTION B: Must be completed only if a health provider or a health plan has requested the authorization.

1. The health plan or health care provider must complete the following:

   a. The information will be used/disclosed for the following purposes:

   - ❑ Continued Patient Care
   - ❑ Disability Determination
   - ❑ Personal Use
   - ❑ Attorney/Legal
   - ❑ Insurance Claim
   - ❑ Other _____

   b. Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____

2. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

3. I understand that I may inspect and copy any information to be used or disclosed.

SECTION C: Must be completed for all authorizations.

1. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires _____
   (Insert applicable date or event that triggers expiration)

2. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

_____ _____
Signature of Patient or Representative Today's Date

_____ _____
Printed Name of Patient's Representative (if applicable) Relationship to Patient

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

WOMEN'S VIEW MEDICAL GROUP

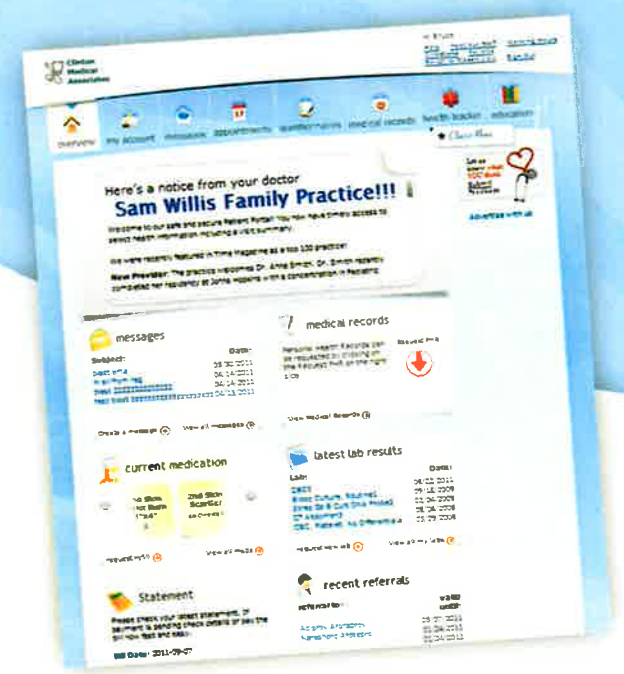
I, _____(Patient) have read a copy of

Women's View Medical Group's Notice of Patient Privacy Practices

_____ _____

Signature of Patient, Parent or legal Guardian Date

Access your own personal
Patient Portal online.



http://www.eclinicalworks.com/products-patient-portal.htm

what is
Patient Portal

Know your **health**...

...Know **yourself**

http://www.eclinicalworks.com/products-patient-portal.htm

Full of Features

This Practice
is now offering our patients easy and private access to their medical information online, so you can view your personal health record whenever and wherever you have access to the Internet!

Gain access to your private health information and receive periodic updates and reminders from your doctor on your personal e-mail address!

what are my **Patient Benefits**

With Patient Portal, you will have access to:

- **Appointments**
  Book and keep track of appointments
- **Lab Results**
  Access and view lab results
- **Medication**
  Request prescription refills
- **Medical Records**
  View your personal health record
- **Education**
  Receive educational materials
- **Messages**
  Send & receive messages from staff
- **Reminders**
  Receive health reminders
- **Billing**
  View & pay billing statements
- **Demographic Information**
  Update demographic information
- **Referrals**
  View & request referrals

how do I **Get Web-Enabled**

To gain access to our secure server on Patient Portal and become web-enabled, simply sign up by providing us with a personal (non-work) e-mail address.

You will be able to securely log in with your username and password, and gain access to your personal health record and other helpful features from any computer or smartphone with an Internet connection!

The Patient Portal is not intended for use in emergencies. If you require urgent or immediate medical care, call 911.