PATIENT INFORMATION Patient ID #: ______________ Sex [ ] Male [ ] Female

Name: ______________________________ Social Security #: ____________________ DOB: ________

Mailing Address: _____________________ Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Other

Street Address: ______________________ Email Address: _______________________________________

City, State, ZIP: _____________________ Primary: [ ]Home [ ]Work [ ]Cell: ______________________

Secondary: [ ] Home [ ] Work [ ] Cell: __________________

Primary Care Physician: ________________________ Phone Number: ____________________________________

Ethnicity: Hispanic ☐ Non-Hispanic ☐ Refused ☐ Race: ___________________ Religion: ___________________

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Unemployed [ ] Self

Employer: _______________________________

Job Title: ________________________________

Phone: __________________________________

PERSONAL / EMERGENCY CONTACTS

Name Relationship Phone

____

____

____

GUARANTOR/RESPONSIBLE BILLING PARTY

[ ] Same as Patient

Name: ___________________________________

Address: _________________________________

City, State, ZIP: ___________________________

Phone: ___________________________________

RESPONSIBLE BILLING PARTY EMPLOYMENT

Employer: ____

Work Phone: _______________________________________

Social Security #: ___________________________________

Date of Birth: ______________________________________

PRIMARY INSURANCE Subscriber: [ ] Patient [ ] Responsible Billing Party [ ] Other

Subscriber Name: _____________________ Relationship to Patient: _______________________________

Subscriber DOB: _____________________ Subscriber Social Security #: __________________________

Insurance Co.: ________________________ Insured ID: _________________ Group #: _______________

SECONDARY INSURANCE Subscriber: [ ] Patient [ ] Responsible Billing Party [ ] Other

Subscriber Name: _____________________ Relationship to Patient: _______________________________

Subscriber DOB: _____________________ Subscriber Social Security #: __________________________

Insurance Co.: ________________________ Insured ID: _________________ Group #: _______________

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF MEDICAL INFORMATION:
I GIVE MY CONSENT FOR TREATMENT.

I herby authorize the release of any appropriate medical information to my insurance company; I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans. This assignment will remain in effect until revoked by me in writing.

Signature: ____ **Date:** ___________________

We make every reasonable effort to obtain pre-approval, prior authorization and referral information. Your co-payment, co-insurance and/or deductible are due in full at the time of service. We will bill your insurance as a courtesy to you. On denied worker compensation claims, the patient's private/group health insurance may be billed. Ultimate financial responsibility remains with the patient and if the insurance company or worker compensation carrier denies payment, the bill is your responsibility. If you are unsure of any of these issues, please ask the staff before you see the physician.

Barton Women's Health

2175 South Avenue
South Lake Tahoe, CA 96150

530-543-5711 TEL
bartonhealth.org

New Patient Form

Patients Name: ______________________________
Date of Birth: ______________________________
Medical Record #: ______________________________

Primary Care Provider: ______________________________

Drug Allergies/Sensitivities: ______________________________

Emergency Phone #: ____________________ Contact Person/Relationship: ____________________
What is the reason for your visit today? ______________________________
____
____

GYN HISTORY

Last Menstrual period: ______________
Age Periods began: ______________
# of Days of bleeding: ______________
# of Days between periods: ______________
Any changes to periods: ______________

Have you ever had sex: ○ Yes ○ No
Are you sexually active currently : ○ Yes ○ No
Sexual partners are: ○ Men ○ Women ○ Both
Method of contraception: ______________

Last pap: ______________
Any abnormal pap? (if yes result/when): ______________
Follow up procedure?: ______________
Exposure to DES in utero: : ○ Yes ○ No
Gardasil Vaccine: ○ Yes/Year_____ ○ No
History of STDs: ○ Yes ________ ○ No

Last Mammogram: ______________
Exercise: ______________ times/week: __________
Calcium/Dairy intake Daily: ______________

PREGNANCY HISTORY

○ Never been pregnant
Total Pregnancies: ____ Full term: ____ Pre Term (< 37wk): ____ Miscarriages: ____ Abortions: ___ Living Children: _____

Date	Weeks	Delivery Type (ex. D&C, Vaginal, cesarean)	Sex	Birth Weight of baby	Name	Delivery location	Complications (ex high blood pressure, diabetes, depression)

PERSONAL MEDICAL HISTORY

Please check box if you have or have had any of the following

○ Asthma
○ Pneumonia / Lung disease
○ Kidney infections/stone
○ Tuberculosis
○ Fibroids
○ STD / Chlamydia
○ Infertility
○ HIV / AIDS
○ Heart Attack / Disease
○ Anemia
○ Stroke
○ Rheumatic Fever
○ Blood Clots in Lungs of legs
○ Eating Disorders
○ Autoimmune Disease (Lupus)
○ Chicken Pox
○ Cancer
○ Reflux / Hiatal Hernia / Ulcers
○ Depression / Anxiety
○ High Blood pressure
○ Seizures /Convulsions
○ Bowel Problems
○ Broken Bones
○ Hepatitis / Liver Disease
○ Gallbladder Disease
○ Headaches
○ Bleeding Disorders
○ Thyroid Disease
○ Diabetes
○ Blood transfusion
○ Other____

MEDICATIONS

Name	Dose	Frequency	Reason
Example: Synthroid	*100mcg*	*Daily*	*Low thyroid*

SURGICAL HISTORY

SURGERY/HOSPITALIZATION	Date

SOCIAL HISTORY

○ Married ○ Single ○ Civil Union ○ Divorced ○ Widow(er) ○ Separated

Sexual Orientation: ____________

Occupation: _______________________

	Current	Former	Never		
Alcohol use	○	○	○	Drinks/wk: __________	Type: ______________
Tobacco use	○	○	○	Packs/day: __________	# of years: __________
Drug use	○	○	○	Type: ______________	# of years: ___________

	Yes	No
Do you wear a seat belt?	○	○
Have you been sexually abused, threatened or hurt by anyone?	○	○

Advance Directive? ○ Yes ○ No If Yes, Date: __________________

Education: ○ Junior HS ○ HS ○ College ○ Graduate Education __________________

FAMILY MEDICAL HISTORY

Mother: ○ Living ○ Deceased, Age: _____ Father: ○ Living ○ Deceased, Age:_______
Siblings: Number living: _______ Number deceased: ________ Cause/Age(s):______________________

Please indicate if there is a family history of any of the following medical illnesses or cancers

Example: Colon cancer Brother 36 yrs Aunt 44years Grandfather 65 yrs
Cousin 58yrs

	Siblings/ Children (age at diagnosis)	**Mother's side (age at diagnosis)**	**Father's side (age at diagnosis)**
Breast Cancer			
Colon Cancer			
Ovarian Cancer			
Uterine Cancer			
Stomach or Bowel Cancer			
Prostate Cancer			
Melanoma			
Pancreatic Cancer			
Other			
High blood pressure			
Heart Disease/Stroke			
Blood Clots			
Diabetes			
Osteoporosis			

REVIEW OF SYMPTOMS

Please check the box if you are experiencing any of the following symptoms:

- O breast pain
- O nipple discharge
- O breast lumps
- O abnormal bleeding
- O painful periods
- O premenstrual syndrome (PMS)
- O pelvic or abdominal pain
- O vaginal dryness
- O painful intercourse
- O abnormal vaginal discharge
- O blood in urine
- O pain with urination
- O very frequent urination
- O chronic cough
- O leg swelling
- O involuntary urinary loss
- O coughing up blood
- O enlarged lymph nodes(glands)
- O fevers
- O muscle weakness
- O significant weight loss
- O significant weight gain
- O excessive fatigue
- O sleep disturbance
- O change in height
- O vision changes
- O depression
- O significant anxiety
- O hearing problems
- O sinus problems
- O chest pain or pressure
- O rapid or irregular heartbeat
- O nausea/vomiting
- O involuntary loss of gas/stool
- O constipation
- O heat or cold intolerance
- O painful breathing
- O hot flashes
- O frequent bruising
- O skin rashes
- O hair loss
- O moles with growth/change
- O dizziness
- O seizures
- O numbness
- O trouble walking
- O memory problems
- O frequent headaches
- O shortness of breath
- O blood in stools
- O blood clots in lungs /legs
- O wheezing
- O frequent diarrhea
- O Other____

O Currently I am experiencing none of the above symptoms

SIGNATURE: ____DATE: ________________

REVIEWED BY: ____DATE: _________________

Preferred Lab

If we send out specimens from our office, i.e., pap smears, blood draws, pathology, etc., your insurance company may have a preference and your benefits could be affected. Please indicate which lab is contracted with your insurance company. If you do not know, please ask one of our receptionists.

________ Barton

________ Lab Corp

________ Quest Diagnostics

________ OTHER - Lab Name & Address:________________________________

Pharmacy: ____

Print Name: ____

Signature: ____

Date: ____________________________

Patient Record of Disclosures

Please fill out completely

Patient Name:	**Date of Birth:**

Who may we release medical information to:

Name: ____
Relationship to you:_______________________

Name: ____
Relationship to you: _______________________

Name: ____
Relationship to you: _______________________

I wish to be contacted in the following manner (check all that applies):

- ☐ **Home Telephone** ____
  - Okay to leave message with detailed information
  - Leave message with call back number and name of Barton Women's Health only
- ☐ **Work Telephone** ____
  - Okay to leave message with detailed information
  - Leave message with call back number and name of Barton Women's Health only
- ☐ **Cellular Phone** ____
  - Okay to leave message with detailed information
  - Leave message with call back number and name of Barton Women's Health only
- ☐ **Other** ____

Signature _________________________________ ***Date*** _______________

CONDITIONS OF REGISTRATION

CONSENT FOR TREATMENT: The undersigned consents to the performance of all routine medical care and treatment, (e.g. laboratory procedures, x-ray examinations, local anesthesia, therapies, etc.) which may be performed on an outpatient basis, under the instruction of the treating provider for each patient. I give my consent for Barton Health, its providers and agents, including debt collectors to place calls to my designated cellular or residential phone using any type of artificial or pre-recorded voice, text message, or auto-dialer technologies for any permissible purpose. (________)initial

FINANCIAL OBLIGATION, BENEFITS ASSIGNMENT AN INTEREST CHARGE NOTICE: I understand I am responsible for all charges incurred. I authorize all insurance benefits to be paid directly to TCVMG and/or Barton Health for services rendered. If my insurance does not cover all charges, I agree to pay any difference upon request. If my account is referred to an attorney or collection agency for collection, I will be responsible for any and all collection expenses including attorney fees. All outstanding accounts are subject to interest at the legal rate.

RELEASE OF INFORMATION: The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the facility may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the facilities charges, including but not limited to insurance companies, health care service plans, or worker's compensation carriers. To ensure coordination of my medical care with my primary care physician, and/or referral source, I authorize release of my medical information.

OTHER BILLS: Patients may also receive separate bills from Radiologist, Pathologist, Physicians, and Ambulance services.

PROP 65: Products used at this facility may contain chemicals known to the State of California to cause cancer, birth defects, and reproductive harm.

NOTIFICATION: The undersigned certifies that he/she has been instructed on how to report concerns related to care, treatment, services, and patient safety issues by calling by calling Barton Memorial Risk Management at 530-543-5845 or the California Department of Public Health Services 916-263-5800.

CHILD SAFETY ALERT: It is illegal to transport a child, under the age of 8 or less than 4ft. 9in. by vehicle without using a federally approved safety seat.

AUTHORIZATION: The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

______________________________	______________	______________________
Patient Signature	Date	Witness Signature
	______________	
	Time	
______________________________	______________	______________________
Guardian/Representative	Date	Relationship

P.O. Box 9578-South Lake Tahoe, CA 96158
Phone (530) 543-5900 – Fax (530) 544-1458

ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Barton Healthcare System's Joint Notice of Privacy Practices.

Patient Name: ____
(please print)

Signature of Patient/Legally Authorized or Personal Representative:

____
(Signature)

Date: ______________________________

If not signed by the patient, please indicate the relationship to patient/authority of person:

____

FOR BARTON USE ONLY:

- ❑ Signed acknowledgment received by: ______________________________
  (BMH staff print name)
- ❑ Acknowledgement refusal received by:______________________________
  (BMH staff print name)

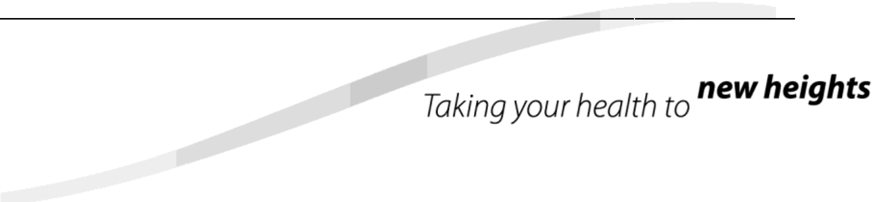
Describe good faith efforts to obtain acknowledgment:

____

Describe reasons why acknowledgment was not obtained:

____

Employee Signature: ____



Date: 4/03/03
Revision Date: 5/19/10; 11/15/17; 5/2018

2175 South Avenue
South Lake Tahoe CA 96150
530.543.5711 TEL
bartonhealth.org

ANNUAL WELLNESS AND OFFICE VISIT Charging

Today you are scheduled for an Annual Wellness visit. If additional services are being provided relating to a diagnosis outside of a wellness diagnosis you may be charged an office visit in addition to your wellness visit. This includes medication refills. By signing this form you acknowledge you have been notified of this.

Patient Name: ______________________________ DOB: ______________

Signature: ________________________________ Date: ______________