PATIENT INFORMATION

Name: ______________________________
Mailing Address: _____________________
Street Address: ______________________
City, State, ZIP: _____________________
Primary Care Physician: ________________________

Patient ID #: _____________ Sex [ ] Male [ ] Female
Social Security #: ___________________ DOB: ________
Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Other
Email Address: ______________________________________
Primary: [ ]Home [ ]Work [ ]Cell: _____________________
Secondary: [ ] Home [ ] Work [ ] Cell: _________________
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.

Return Annual Form

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

Primary Care Provider: ______________________________
Drug Allergies/Sensitivities: ______________________________
What is the reason for your visit today? ☐ Annual Exam, ☐ Any Other Complaint, Please Explain
____
____

GYN HISTORY UPDATE

Last Menstrual period: __________________
Periods are ☐ Regular ☐ Irregular ☐ No Periods
Any changes to periods: __________________
Are you taking hormone therapy?: ☐ Yes ☐ No
Are you sexually active currently: ☐ Yes ☐ No
Method of contraception: __________________
Have you been sexually abused, threatened or hurt by anyone? ☐ Yes ☐ No
Alcohol ☐ Yes ☐ No How many drinks per week? ____

HEALTH CARE MAINTENENCE

Last pap test:__________Results:________________
Colonoscopy: ☐No ☐Yes, Date________
Results:______________________________
Last Mammogram: ☐No ☐Yes, Date______________
Results:______________________________
Bone Density Screening: ☐No ☐Yes, Date________
Results:______________________________
Exercise: ______________minutes/week:__________

SURGICAL/ MEDICAL HISTORY UPDATE

New or changes in existing medical problems since last visit? ☐ No ☐ Yes ______________________
New surgeries or hospitalizations since last visit? ☐ No ☐ Yes______________________

FAMILY MEDICAL HISTORY UPDATE

Any new illnesses in your family? ☐ No ☐ Yes ______________________

REVIEW OF SYMPTOMS

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

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

☐ Currently I am experiencing none of the above symptoms

SIGNATURE: ______________________________

2175 South Avenue
South Lake Tahoe CA 96150
530.543.5711 TEL
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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: ______________