600 N. MOUNTAIN AVE., SUITE A104 UPLAND, CA. 91786
(909) 931-1033 FAX (909) 981-8976
Hours: 8:30am – 5:30pm
Closed between 12:30pm – 1:30pm

On behalf of the entire staff of Women's Medical Group of Upland, I would like to welcome you to our practice. We are looking forward to seeing you at your first appointment on:

Date: _______________________at________________

We must receive at least 24 hour notice if you are unable to keep this appointment.

You will find a packet of forms attached to this letter that we would appreciate you filling out completely and bringing to your first appointment. Please include any special questions or concerns you may have. It is also very important that you bring your insurance card. **INSURANCE CARD AND VALID GOVERNMENT ISSUED ID** MUST BE PRESENTED AT TIME OF SERVICE, IF **INSURANCE CARD AND GOVERNMENT ID** IS NOT PROVIDED APPOINTMENT WILL BE RESCHEDULED. THIS IS A STRICT POLICY PER THE FEDERAL TRADE COMMISSION EFFECTIVE AUGUST 01, 2009. WE APOLOGIZE FOR ANY INCONVENIENCE. Check In Time is **15min Prior** to Appointment Time, with the exception of the 8:30am and 1:30pm appointments.

Should you have any other questions before your appointment please feel free to call us at the number above.

We look forward to meeting you!

Sincerely,

Women's Medical Group of Upland

WOMEN'S MEDICAL GROUP OF UPLAND, INC.
600 N. Mountain Ave., Suite A104 Upland, CA. 91786
(909) 931-1033 FAX (909) 981-8976

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security #:	Home phone #: ( )

City:	State:	ZIP Code:	P.O. box:

Occupation:	Employer & Address:	Employer phone #: ( )

Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Mailing Address (if different):	Home phone #: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary insurance carrier:	

Subscriber's name:	Subscriber's S.S. # (Req.):	Birth date: / /	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance whether or not paid by my insurance. I also authorize Women's Medical Group of Upland or insurance company to release any information required to process my claims.

____

Patient/Guardian signature *Date*

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ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACEY PRACTICES

I acknowledge that a copy of the current Notice of Privacy Practices is posted in the reception area. I agree to read this notice at my convenience.

Print Name: ____

Signature: ____

Date: ______________________________

If not signed by patient please indicate:

Relationship:

_______ Parent / Guardian

_______ Beneficiary or Personal Representative

Patient Name: ____

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Please be advised that any lab fees and/ or bills that you may receive from the laboratory where your lab results are sent **are not** the responsibility of this office. Please contact your insurance if you are not sure what is covered by your insurance carrier.

Please sign that you have received this notice.

____ Date: ____________________

Thank you,

Women's Medical Group

600 N. Mountain Ave., Suite A104 Upland, CA. 91786
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Billing Policy and Procedures:

- The patient will be charged a fee of $25.00 for any appointment not cancelled within 24hrs prior to scheduled time.

- Courtesy billing is provided when the proper information has been furnished by the patient. This includes insurance cards, billing addresses, and subscriber information. If this information is not provided prior to billing it will be the patient's responsibility to pay for the services rendered.

- If the insurance company does not cover the patient's bill in full it is the responsibility of the patient to cover any balance. The balance on the account will be billed and is expected to be paid promptly or payment arrangements made.

- Not all services are covered benefits of all insurance contracts. The patient is responsible for knowing whether or not their insurance will cover a certain service needed. In the event that the insurance company does not cover the services the payment for services are the patient's responsibility.

- It is the patient's responsibility to check with the insurance company regarding prior authorization before having services performed.

- **HMO** patients: it is the patient's responsibility to make sure that the policy is effective with **Primecare Medical Group of Inland Valley**. Insured patient's that are not an active member with Primecare Medical Group of Inland Valley and do not have a Point of Service plan will be treated as cash paying patients. All co-pays are due at the time services are rendered.

- Medicare assignment is accepted. As a courtesy we will bill the secondary insurance one time. Any balance not covered will be the patient's responsibility.

- **All co-pays** and deductibles are payable at the time services are rendered with the exception of surgical and obstetrical patient's. Patient's scheduled for surgeries are required to have the patient portion paid by the Pre-Op appointment. Obstetrical patients are responsible for payment as outlined in the OB Contract provided by our office.

- All accounts are due and payable within 60 days from the date of service unless arrangements have been made.

Signature Patient/Responsible party ____ Date: _________________

Medical History

Gynecologic History		Past Medical History	
Name	Date	Name	Date
☐ Abnormal Pap Smear	________	☐ Anemia	________
☐ Abnormal Uterine Bleeding	________	☐ Arthritis	________
☐ Amenorrhea	________	☐ Asthma	________
☐ Bartholin’s Gland Cyst	________	☐ Breast Cancer, Female	________
☐ Chlamydia	________	☐ Breast Cyst, Benign	________
☐ Condyloma Acuminatum	________	☐ Chickenpox	________
☐ Cystocele	________	☐ Coagulation Defect	________
☐ DES Exposure	________	☐ Colon Cancer, Personal History	________
☐ Dysmenorrhea	________	☐ Congestive Heart Failure	________
☐ Dyspareunia	________	☐ Coronary Artery Disease	________
☐ Dysplasia of Cervix	________	☐ Crohn’s Disease	________
☐ Dysplasia of Vagina	________	☐ Deep Vein Thrombosis	________
☐ Endometrial Cystic Hyperplasia	________	☐ Diabetes Mellitus, Type I	________
☐ Endometriosis	________	☐ Diabetes Mellitus, Type II	________
☐ Fibroids, Uterine	________	☐ Diverticulosis of Colon	________
☐ Herpes Simplex, Genital	________	☐ Emphysema	________
☐ Human Papilloma Virus Infection(HPV)	________	☐ Epilepsy	________
☐ Incontinence of Urine	________	☐ Esophageal Reflux	________
☐ Infertility, Female	________	☐ Fibrocystic Changes of the Breast	________
☐ Irregular Mensus	________	☐ Gallbladder Disorder	________
☐ Ovarian Cancer, Personal History	________	☐ Gastric Ulcer	________
☐ Ovarian Cyst	________	☐ Glaucoma	________
☐ Pelvic Inflammatory Disease	________	☐ Headache	________
☐ Pelvic Mass	________	☐ Heart Valve Replacement	________
☐ Pelvic Pain	________	☐ Hematuria	________
☐ Polycystic Ovaries	________	☐ Hepatitis	________
☐ Postcoital Bleeding	________	☐ Human Immunodeficiency Virus (HIV)	________
☐ Postmenopausal Bleeding	________	☐ Hypercholesterolemia	________
☐ Premenstral Tension Syndrome	________	☐ Hypercoagulation Syndrome	________
☐ Rectocele	________	☐ Hypertension, Essential	________
☐ Sexual Dysfunction	________	☐ Irritable Bowel Syndrome	________
☐ Syphilis	________	☐ Kidney Calculus	________
☐ Urinary Tract Infection	________	☐ Liver Disease	________
☐ Uterine Prolapse	________	☐ Melanoma	________
☐ Vaginal Wall Prolapse	________	☐ Osteoporosis	________
☐ Vevereal Disease	________	☐ Previous Blood Transfusion	________
☐ Vulvovaginitis	________	☐ Psychiatric Problems	________
☐ Other ________		☐ Sickel Cell Anemia	________
________		☐ Stroke	________
________		☐ Thyroid Disorder	________
________		☐ Ulcerative Colitis	________
________		☐ Urinary Tract Infection	________
________		☐ Other ________	
		________	
		________	
		________	
		________	

Past Surgical History

Gynecological Surgery	Date
☐ Abdominal Hysterectomy	______________
☐ Anterior Vaginal Repair	______________
☐ Burch Procedure	______________
☐ Cesarean Section	______________
☐ Conization	______________
☐ Cryosurgery	______________
☐ Dilation and Curettage	______________
☐ Ectopic Pregnancy Removal	______________
☐ Essure	______________
☐ Hysteroscopy	______________
☐ Laparoscopic Assisted Hysterectomy	______________
☐ Laparoscopic Tubal Ligation	______________
☐ Laparoscopy	______________
☐ Leep	______________
☐ Myomectomy	______________
☐ Oophorectomy	______________
☐ Ovarian Cystectomy	______________
☐ Paravaginal Repair	______________
☐ Posterior Repair	______________
☐ Salpingoctomy	______________
☐ Salpingo-oophorectomy	______________
☐ Sling Procedure	______________
☐ Tubal Ligation	______________
☐ TVT Sling	______________
☐ Vaginal Delivery	______________
☐ Vaginal Hysterectomy	______________
☐ Other ______________________________________	

Family Medical History

Disease Name	Relative/Age
☐ Breast Cancer	______________
☐ Cerebrovascular Disease	______________
☐ Cervical Cancer	______________
☐ Colon Cancer	______________
☐ Colon Polyps	______________
☐ Coronary Artery Disease	______________
☐ Diabetes Hypercholesterolemia	______________
☐ Hypercoagulation Syndrome	______________
☐ Hypertension, Essential	______________
☐ Osteoporosis	______________
☐ Ovarian Cancer, Family History	______________
☐ Tuberculosis	______________
☐ Uterine Cancer	______________
☐ Other ______________________________________	

Common Surgery

Name	Date
☐ Appendectomy	______________
☐ Back Surgery	______________
☐ Breast Implants	______________
☐ Breast Reduction	______________
☐ CABG	______________
☐ Cholecystectomy	______________
☐ Cystoscopy	______________
☐ Hernia Repair	______________
☐ Hip Surgery	______________
☐ Knee Surgery	______________
☐ Lumpectomy (Breast)	______________
☐ Mastectomy	______________
☐ Thyroidectomy	______________
☐ Other ______________________________________	

Genetic History

Name	Date
☐ Anomaly, Congenital	______________
☐ Cardiac Anomaly, Congenital	______________
☐ Cystic Fibrosis	______________
☐ Down Syndrome	______________
☐ Fragile X Syndrome	______________
☐ Hemophilia	______________
☐ Kidney Anomalies	______________
☐ Kidney Disease, Cystic	______________
☐ Marfan Syndrome	______________
☐ Mental Retardation, Family History	______________
☐ Neural Tube Defect	______________
☐ Polycystic Kidney, Autosomal Dominant	______________
☐ Sickle Cell Anemia	______________
☐ Spina Bifida	______________
☐ Tay-Sachs Disease	______________
☐ Thalassemia	______________
☐ Turner’s Syndrome	______________
☐ Uterus Anomaly, Congenital	______________
☐ Ventricular Septal Defect	______________
☐ Other ______________________________________	

Pregnancy History

☐ Total Number of Pregnancies	______________
☐ Full Term Pregnancies	______________
☐ Premature Pregnancies	______________
☐ Number of Miscarriages/Abortions	______________
☐ Living Children	______________

Menstrual History

☐ Age Menarche	______________
☐ Interval	______________
☐ Duration	______________
☐ Last Menstrual Period	______________
☐ Menopause Status	______________
☐ (if menopause) Age	______________
☐ Birth Control Method	

Social History		Allergy List
Finding	Amount Used	
☐ Alcohol	______	______
☐ Amphetamines	______	______
☐ Caffeine	______	______
☐ Cocaine	______	______
☐ Depressants	______	______
☐ Ecstasy	______	______
☐ Hallucinogens	______	______
☐ Inhalants	______	______
☐ IV Drug Abuse	______	______
☐ Marijuana	______	______
☐ Narcotics	______	______
☐ Stimulants	______	______
☐ Tobacco	______	______
☐ Other Substance Use	______	______

Medication History

Current Medication	Indication	Dosage	Prescribing Doctor
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
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______	______	______	______
______	______	______	______
______	______	______	______

UROGYNECOLOGIC QUESTIONNAIRE

I urinate every ______ hours during the day.
At night, I get up ______ times to urinate.

Question	Response
Do you lose urine in spurts with laughing, sneezing, or exertion?......................	Yes No
What amount of urine do you lose?..	Small Large Both
In what position do you lose urine?..	Sitting Standing Lying down
Do you lose urine with a strong sense of urgency?..	Yes No
Does the sound, sight, or feel of running water make you lose urine?.......	Yes No
Do you lose urine without any warning (without activity or urgency)?..............	Yes No
Do you wear a pad all of the time?..	Yes No
Is it difficult to get the urine stream started?..	Yes No
Does your urine stream seem slow or weak?..	Yes No
Do you feel that you empty your bladder completely when you urinate?	Yes No
Do you have pain associated with urination?..	Yes No
Do you have frequent bladder infections?..	Yes No
Do you feel as if your pelvic organs are "falling down"?................................	Yes No
Do you feel a bulge at the opening of your vagina?................................	Yes No

BOWEL FUNCTION QUESTIONNAIRE

□ Skip this section. I have no problems with my bowel function.

I move my bowels ______ times per day or ______ times per week.

Question	Response
Do you have difficulty emptying your rectum?..	Yes No
What is the consistency of your stool when this happens?.........................	Liquid Soft Normal Hard
Does it help to press on the inside or outside of the vagina?......................	Yes No
Do you lose control of stool?..	Yes No
What is the consistency of your stool when this happens?.........................	Liquid Soft Normal Hard
Do you have problems controlling gas?..	Yes No
Do you have alternating constipation and diarrhea?....................................	Yes No
Do you have pain with bowel movements?..	Yes No
Do you ever see blood in your stools?..	Yes No

COSMETIC GYNECOLOGY QUESTIONNAIRE

□ Skip this section. I have no problems with the appearance or function of my genital region

Question	Response
I am self-conscious about the appearance of my vulva/vagina......................	Yes No
I am unhappy with the way my vagina looks (i.e. gaping)...........................	Yes No
I am unhappy with the way my labia look (irregular, dark, long)..................	Yes No
My labia rub or pull on my clothing or during sex.....................................	Yes No
I am unable to wear the type of clothing that I want..................................	Yes No
My vagina feels loose during sex..	Yes No
I have decreased sensation during sex..	Yes No
I wish to enhance my pleasure with sex...	Yes No
I want cosmetic vaginal surgery..	Yes No

SEXUAL FUNCTION QUESTIONNAIRE

□ Skip this section. I do not have any problems with my sexual functioning.

Sexual orientation: □ heterosexual □ homosexual □ bisexual

Question	Response
I have low desire to participate in sexual activity.....................................	Yes No
I am unable to reach orgasm	Yes No
I have significant difficulty reaching orgasm...	Yes No
I have a difficult time becoming aroused during sexual activity....................	Yes No
I do not become sufficiently lubricated with sexual activity.........................	Yes No
I experience pain with vaginal penetration..	Yes No