



Patient Information

Patient Name _____ DOB _____ SSN _____ - _____ - _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Best Phone Number (where a private message can be left) _____

Email Address _____

Can we email personal medical information (i.e. results, treatment protocols)? Yes / No

Patient Occupation _____ Patient Employer _____

Business Address _____

Pharmacy Name _____ Phone # _____

Partner Name _____ DOB _____ SSN _____ - _____ - _____

Partner Occupation _____ Partner Employer _____

Partners Business Address _____

Partners Phone # _____ Work _____ Cell _____

Emergency Contact Name _____ Relationship _____ Phone Number _____

Purpose of Visit _____

How did you learn of this practice? Friend Relative Internet Insurance

Other _____

Referring/Personal Physician Name _____

Address _____

Authorization of Treatment Assignment of Benefits, Release of Medical Information, Financial Responsibility I understand that I am financially responsible for charges incurred at the time of service or for any charges not covered by an approved contractual provider insurance or insured benefits. I am also responsible for any collection fees or legal costs incurred should costs be necessary because of non-payment. I hereby authorize the release of any medical records or other information necessary for the processing of insurance benefits of medical and/or surgical services rendered. I hereby authorize payment of benefits directly to the West Coast Women's Reproductive Center for procedural, surgical and /or medical benefits. HMO patients should be aware that you are financially responsible for all unauthorized services. I hereby authorize treatment.

Signature of Patient: _____ Date: _____



WEST COAST
WOMEN'S REPRODUCTIVE CENTER™

Together, we'll find a way.

4835 Van Nuys Blvd. Suite 200 Sherman Oaks, CA 91403 | ph 818-986-1648 | fax 818-986-1653 | WomensReproduction.com

Confidential Channel Communication Request

As required by the Health Information Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided and, as appropriate, information as to how payment will be handled.

I, _____, hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment, or payment for treatment.

Phone

I want you to contact me by telephone at _____

Do Do Not Leave messages on my answering machine

Do Do Not Leave messages with any other person, if so

With: _____

Relationship: _____

Mail

I want you to contact me at the following address:



4835 Van Nuys Blvd. Suite 200 Sherman Oaks, CA 91403 | ph 818-986-1648 | fax 818-986-1653 | WomensReproduction.com

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge that the medical practice's Notice of Privacy Practices has been made available to me, and upon my request I will receive a copy of it. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Print Patient's Name

Patient's Signature

Date

Time

_____ **FOR**
OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because.

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement Other (Please
- Specify)

Email Communication Policy

For many patients, email serves as an effective form of communication with their nurse or doctor. Though in many instances email communication may be very efficient, there are several things that you must consider.



4835 Van Nuys Blvd. Suite 200 Sherman Oaks, CA 91403 | ph 818-986-1648 | fax 818-986-1653 | WomensReproduction.com

- If you request to communicate with a physician or staff member of our office via email, it is possible that such email could be received by a person other than yourself unintentionally; therefore it is possible that any Protected Health Information contained in such an email would be viewed by someone other than yourself.*
- Our email program is not part of a secured system; therefore it is not encrypted nor protected by a firewall.
- Every effort is made to have all incoming emails into our system read within 48 hours. However, this is not always possible. Therefore, if you have not received a response within 72 hours do not assume that your email has been read. At this point, you should try to reinitiate contact with whomever you are trying to reach either by email or through a direct phone call to the office.
- Urgent matters should **NOT** be addressed by email. This includes but is not limited to; immediate prescription refill requests, appointment requests, and medical complications.
- Emergency matters should **NOT** be addressed by email. This includes but is not limited to: abdominal pain, bleeding, fevers, post-operative complications.

If you have an emergency during office hours please call the office immediately. If you have an emergency either during the receptionists' lunch hour (12pm-1pm) or after hours, call the office and follow the instructions on the voicemail to speak with your physician (or the weekend doctor on call). If you do not hear back from the doctor on call within 15 minutes, please call again. The office number is 818-986-1648.

** Confidential health information is protected by state and federal law, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and related regulations.*

The signature below signifies that I have read the above email communication policy and agree to abide by it.

Signature of patient or patient's representative _____ date: ____



WEST COAST
WOMEN'S REPRODUCTIVE CENTER™

Together, we'll find a way.

4835 Van Nuys Blvd. Suite 200 Sherman Oaks, CA 91403 | ph 818-986-1648 | fax 818-986-1653 | WomensReproduction.com

Name: _____ Age: _____ Date of Birth _____ Partners Name _____

Cell Phone _____ Email: _____ Primary Physician: _____

Referred By: _____

MEDICAL HISTORY: Do you have or have you ever had (check all that apply)

<input type="checkbox"/> HIGH CHOLESTEROL	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> IRREGULAR PERIODS
<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> UTERINE CANCER	<input type="checkbox"/> FEMALE/SEXUAL PROBLEMS
<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> OVARIAN CANCER	<input type="checkbox"/> ECTOPIC
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> CERVICAL CANCER	<input type="checkbox"/> STDS- (GONORRHEA/CHLAMYDIA, Herpes, HIV, other)
<input type="checkbox"/> DIABETES	<input type="checkbox"/> BREAST MASS/ABNORMAL MAMMO	<input type="checkbox"/> BIRTH DEFECTS/INHERITED disease
<input type="checkbox"/> THYROID DISEASE	<input type="checkbox"/> BREAST CANCER	<input type="checkbox"/> SEXUAL ABUSE, DOMESTIC VIOLENCE
<input type="checkbox"/> LIVER DISEASE/HEPATITIS	<input type="checkbox"/> AUTO IMMUNE DISEASE	<input type="checkbox"/> ABNORMAL PAP/DETAILS:
<input type="checkbox"/> STOMACH/BOWEL	<input type="checkbox"/> FIBROIDS	<input type="checkbox"/> ACNE/EXTRA HAIR
<input type="checkbox"/> KIDNEY/BLADDER PROBLEMS	<input type="checkbox"/> INFERTILITY- UNEXPLAINED/OTHER	<input type="checkbox"/> BLOOD DISEASE
<input type="checkbox"/> GALL BLADDER	<input type="checkbox"/> INFERTILITY--male	<input type="checkbox"/> OTHER MEDICAL PROBLEM
<input type="checkbox"/> BLOOD TRANSFUSION	<input type="checkbox"/> INFERTILITY-tubal	<input type="checkbox"/> NO MEDICAL PROBLEM
<input type="checkbox"/> BLOOD CLOTS	<input type="checkbox"/> INFERTILITY- irregular cycles	<input type="checkbox"/> DETAILS

SURGICAL HISTORY: HAVE YOU EVER HAD SURGERY: IF YES, PLEASE EXPLAIN (or been in hospital)

_____ date _____
_____ date _____



WEST COAST
WOMEN'S REPRODUCTIVE CENTER™

Together, we'll find a way.

4835 Van Nuys Blvd. Suite 200 Sherman Oaks, CA 91403 | ph 818-986-1648 | fax 818-986-1653 | WomensReproduction.com

MEDICATIONS: Any Prescription Medications?

Any over the counter meds or herbs?

Do you have any allergies to medicines? _____ to foods? _____ other? _____

NO KNOWN DRUG ALLERGIES

Social History – Do you use or have you used:

TOBACCO: _____ Per Day _____ Per Month _____ Quit _____

ALCOHOL: _____ Per Day _____ Per Month _____ Quit _____

DRUGS: (explain) _____ Caffeine/Day: _____

Exercise: ___ Yes ___ No ___ Hours Per Day ___ Per Week Details: _____

Have you Lost _____ Gained _____ more than 20lbs in the last year

Diet: any foods you avoid, any special diets: ___ VEGAN ___ VEGETARIAN

___ PESCADARIAN ___ PALEO ___ GLUTEN FREE ___ Kosher OTHER: _____

Gynecology History:

Age First Period: _____ Days Between Cycles: _____ # Days of Bleeding _____

Is your period? Heavy _____ Medium _____ Light _____ Painful _____

Birth Control Method: _____ Pills _____ IUD _____ Ring _____ Patches _____ Condoms

_____ Tubal _____ Vasectomy _____ Depo Shot _____ Withdrawal _____ Foams/Jellies/Sponge Last Period

_____ Last Pap _____ Last Mammogram: _____ # partners in your life: _____

Fertility Treatments:

Evaluation: Blood Test _____ Ultrasound _____ HSG _____ Semen Test _____

Clomid: _____ Letrozole: _____ Gonadotropins (shots): _____ IVF _____ ICSI _____

OB History:

Pregnancies _____ # Births _____ (# C/Sections _____) # Miscarriages _____

Abortions _____ # Ectopic _____ Other _____

Pregnancy Date	Fertility Treatment	Weight at Birth	Delivery	Complications



Family History – Do any of your relatives have any of the following? (especially mom, dad, siblings and grandparents)

<input type="checkbox"/> HIGH CHOLESTEROL	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> IRREGULAR PERIODS
<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> UTERINE CANCER	<input type="checkbox"/> PROSTATE CANCER
<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> OVARIAN CANCER	<input type="checkbox"/> LYMPHOMA/LEUKEMIA
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> CERVICAL CANCER	<input type="checkbox"/> GENETIC DISEASE
<input type="checkbox"/> DIABETES	<input type="checkbox"/> PANCREATIC CANCER	<input type="checkbox"/> BIRTH DEFECTS/INHERITED DISEASE
<input type="checkbox"/> THYROID DISEASE	<input type="checkbox"/> BREAST CANCER	<input type="checkbox"/> BLOOD DISEASE
<input type="checkbox"/> LIVER DISEASE/HEPATITIS	<input type="checkbox"/> COLON CANCER	<input type="checkbox"/> BLOOD CLOTS
<input type="checkbox"/> STOMACH/BOWEL/GALLBLADDER	<input type="checkbox"/> FIBROIDS	<input type="checkbox"/> AUTO IMMUNE DISEASE
<input type="checkbox"/> KIDNEY/BLADDER PROBLEMS	<input type="checkbox"/> INFERTILITY	<input type="checkbox"/> OTHER MEDICAL PROBLEM

Your Ethnicity: check all that apply

___ Caucasian ___ African American ___ Hispanic ___ Latino ___ Asian ___ Native American
___ Indian ___ Pacific Islander ___ Ashkenazi Jewish ___ Sephardic Jewish ___ Mediterranean

Your Partners: check all that apply

___ Caucasian ___ African American ___ Hispanic ___ Latino ___ Asian ___ Native American
___ Indian ___ Pacific Islander ___ Ashkenazi Jewish ___ Sephardic Jewish ___ Mediterranean