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

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:

_____

_____

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

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.

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

- 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)

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

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

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

□ HIGH CHOLESTEROL	□ ANEMIA	□ IRREGULAR PERIODS
□ HEART DISEASE	□ UTERINE CANCER	□ PROSTATE CANCER
□ HIGH BLOOD PRESSURE	□ OVARIAN CANCER	□ LYMPHOMA/LEUKEMIA
□ ASTHMA	□ CERVICAL CANCER	□ GENETIC DISEASE
□ DIABETES	□ PANCREATIC CANCER	□ BIRTH DEFECTS/INHERITED DISEASE
□ THYROID DISEASE	□ BREAST CANCER	□ BLOOD DISEASE
□ LIVER DISEASE/HEPATITIS	□ COLON CANCER	□ BLOOD CLOTS
□ STOMACH/BOWEL/GALLBLADDER	□ FIBROIDS	□ AUTO IMMUNE DISEASE
□ KIDNEY/BLADDER PROBLEMS	□ INFERTILITY	□ 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