

Welcome to Sunshine Women's Medical Center!

Catherine S. Song, MD

Today's Date: _____

Patient Name:			Date of Birth:			
Address:			Social Security #:			
City:	State:	Zip:	Home Phone:			
Employer:			Work Phone:		Cell:	
Company Address:			Supervisor:			
City:	State:	Zip:	Marital Status: M S W D			
Emergency Contact Name:			Relationship:			
Address:			Phone:			
Insurance Co.:		Primary Subscriber is: Self ___ Spouse ___ Parent ___ Other ___				
Subscriber's Name:			Date of Birth:			
Subscriber's Address:			Social Security #:			
City:	State:	Zip:				
Subscriber's Employer:			Work Phone:			
Company Address:			Supervisor:			
City:	State:	Zip:				
**Are you covered on any other insurance plan? ___ Yes ___ No If yes, what plan?						
**Who may we thank for referring you?			Telephone #:			

Office Policy On Payment:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 60 days will be charged an interest rate of 1 1/2 percent per month (18% per annum) or a \$2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance, including a reasonable attorney's fee.

Insurance Policy:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you, we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with the policy numbers, address, place of employment and any other pertinent information. *You are responsible for all deductibles and charges not covered by insurance.* Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations – this is your responsibility.

Authorization For Treatment and Release Of Medical Records:

I authorize the Doctor to treat me (or minor in my care) and release any medical information including diagnosis, x-rays, test results, reports, and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary, in order to ensure the best medical care on my behalf. I further understand that any person(s) that receives these medical records will not release any of the medical information obtained by this authorization to any other person or organization without further authorization signed by me for release of the information.

I have read the above, and accept financial responsibility in full for this account.

SIGNED: _____ DATE: _____
 Patient (Parent, or Guardian, if minor)

Sunshine Women's Medical Center

Notice of Privacy Practices Written Acknowledgement Form

I, _____, have received and read a
Name of Patient
copy of Sunshine Women's Medical Center's Notice of Privacy Practices.

Signature of Patient

Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us.

We are required by applicable federal and state law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to maintain the privacy of your medical information. We are also required to give notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law, for all medical information that we maintain, including medical information created or received before we made any changes.

We may use and disclose medical information about you for the following purposes:

Treatment – We may use your medical information to treat or disclose your medical information to a physician or other health care provider providing treatment to you.

Payment – We may use and disclose your medical information to obtain payment for services we provide you.

Healthcare Operations – We may use and disclose your medical information in connection with the normal course of operating our practice. These may include quality assessment activities, performance evaluations, conducting training programs, accreditation and certification, licensing or credentialing activities.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures of your medical information will only be made with your written authorization or in response to legal requirements such as disaster relief, court orders, suspected abuse, neglect, or domestic violence, or in certain instances affecting national security.

You have the following rights with respect to your protected health information which you may exercise by written request:

- (1) You have the right to request additional restrictions on the use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement which must be in writing.
- (2) You have the right to inspect and copy your protected health information. Charges may apply.
- (3) You have the right to request amendments to your protected health information.
- (4) You have the right to receive an accounting of disclosures of your personal health information for other than treatment, payment, health care operations or pursuant to other authorized disclosures as stated above.
- (5) You have a right to obtain a copy of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we have made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may contact us using the contact information listed at the end of this notice. You may also submit a written complaint to the US Department of Health and Human Services (DHHS). We will provide you with the address to file your complaint upon request.

Contact Office: Sunshine Women's Medical Center, Dr. Catherine Song, 4213 Dale Road, Suite 1, Modesto, CA 95356, (209) 543-7400, FAX (209) 543-7403

Sunshine Women's Medical Center

PATIENT INTAKE HISTORY

Patient Name:	Today's Date:
Referred by:	Birth Date:
Why have you come into the office today?	
Please describe your problem; Is it new, when did it start, and how severe is it?	

GYNECOLOGIC HISTORY

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

Last normal menstrual period (first day):	Present method of birth control:
Age periods began:	Have you ever used an intrauterine device (IUD) or birth control pills?
Length of periods (number of days of bleeding)	If yes, for how long?
Number of days between periods:	Date of your last PAP test?
Any recent changes in periods?	What was the result?
Are you currently sexually active?	Have you ever had an abnormal PAP test?
Number of sexual partners (lifetime):	If yes, give date:
Any history of sexually transmitted disease? If so, what?	Do you do regular breast self-exams?
Sexual partners are: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both	Date of your last mammogram?

OBSTETRIC HISTORY

Pregnancies		NUMBER		Abortions		NUMBER		Miscarriages		NUMBER	
Premature Births (< 37 weeks)				Live Births				Living Children			
NO.	BIRTH DATE	WEIGHT @ BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (Vaginal, Cesarean, etc.)	COMPLICATIONS					
1.											
2.											
3.											
4.											
5.											
6.											

CURRENT MEDICATIONS

DRUG NAME	DOSAGE	WHO PRESCRIBED
1.		
2.		
3.		
4.		
5.		

ALLERGIES:

<input type="checkbox"/> NO ALLERGIES

Patient Name:	Birthdate:	Date:
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FAMILY HISTORY

Mother <input type="checkbox"/> Living <input type="checkbox"/> Deceased		Age:	Father <input type="checkbox"/> Living <input type="checkbox"/> Deceased		Age:
Siblings: Number living:		Number Deceased:	Cause(s) / Age(s):		
Children: Number living:		Number Deceased:	Cause(s) /Age(s):		
ILLNESS	•	WHICH RELATIVE(S) AND AGE OF ONSET	•	ILLNESS	WHICH RELATIVE(S) AND AGE OF ONSET
Diabetes				Birth Defects	
Stroke				Mental Illness/Depression	
Heart Disease				Breast Cancer	
High Blood Pressure				Colon Cancer	
High Cholesterol				Ovarian Cancer	
Osteoporosis (Weak Bones)				Uterine Cancer	
Hepatitis				HIV/AIDS	
Tuberculosis				Other	

SOCIAL HISTORY

	YES	NO		YES	NO
Do You Smoke? Packs per day: _____			Regular Exercise? How long, how often?		
Alcohol: Drinks per day: Drinks per week:			Dairy Intake/Calcium supplements		
Recreational / Illicit Drug Use			Have you been sexually abused, threatened, or hurt by anyone?		

PERSONAL PROFILE

Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Living with partner <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Number of Living Children:
School Completed: <input type="checkbox"/> High School <input type="checkbox"/> Some College/AA Degree <input type="checkbox"/> College <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Other
Current or Most Recent Job:

PERSONAL / PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	MAJOR ILLNESSES	YES (DATE)	NO
Asthma			Cancer		
Pneumonia/Lung Disease			Reflux/Hiatal Hernia/Ulcers		
Kidney Infections/Stones			Depression/Anxiety		
Tuberculosis			Anemia		
Sexually Transmitted Disease			Blood Transfusions		
HIV/AIDS			Seizures/Convulsions/Epilepsy		
Heart Attack/Problems			Bowel Problems		
Diabetes			Glaucoma		
High Blood Pressure			Cataracts		
Stroke			Arthritis/Joint Pain/Back Problems		
Rheumatic Fever			Broken Bones		
Blood Clots in Lungs or Legs			Thyroid Disease		
Eating Disorders			Hepatitis/Yellow Jaundice/Liver Disease		

OPERATIONS / HOSPITALIZATIONS

REASON	DATE	HOSPITAL

Patient Name:	Birthdate:	Date:
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REVIEW OF SYSTEMS
PLEASE CHECK (•) IF ANY OF THE FOLLOWING SYMPTOMS APPLY TO YOU NOW

	YES	NO		YES	NO
1. CONSTITUTIONAL			7. GENITOURINARY (continued)		
Weight Loss			Abnormal Bleeding		
Weight Gain			Painful Periods		
Fever			Premenstrual Syndrome (PMS)		
Fatigue			Painful Intercourse		
2. EYES			Fibroids		
Spots Before Eyes			Infertility		
Vision Changes			DES Exposure		
3. EAR, NOSE AND THROAT			Abnormal Vaginal Discharge		
Earaches			8. MUSCULOSKELETAL		
Hearing Problems			Muscle Weakness		
Sinus Problems			Muscle or Joint Pain		
Sore Throat			9a. SKIN		
Mouth Sores			Rash		
Dental Problems			Sores		
4. CARDIOVASCULAR			9b. BREASTS		
Painful Breathing			Pain in Breast		
Chest Pain or Pressure			Nipple Discharge		
Difficulty Breathing on Exertion			Lumps		
Swelling of Legs			10. NEUROLOGIC		
Rapid or Irregular Heartbeat			Dizziness		
5. RESPIRATORY			Seizures		
Wheezing			Numbness		
Spitting Up Blood			Trouble Walking		
Shortness of Breath			Severe Memory Problems		
Chronic Cough			Frequent or Severe Headaches		
6. GASTROINTESTINAL			11. PSYCHIATRIC		
Frequent Diarrhea			Depression or Frequent Crying		
Bloody Stool			Severe Anxiety		
Nausea/Vomiting/Indigestion			12. ENDOCRINE		
Constipation			Hair Loss		
Involuntary Loss of Gas or Stool			Heat/Cold Intolerance		
7. GENITOURINARY			Abnormal Thirst		
Blood in Urine			Hot Flashes		
Pain With Urination			13. HEMATOLOGIC/LYMPHATIC		
Frequent Urination			Frequent Bruises		
Incomplete Emptying			Cuts Do Not Stop Bleeding		
Involuntary Urine Loss			Enlarged Lymph Nodes (Glands)		
Urine Loss / Coughing or Lifting			14. ALLERGIC/IMMUNOLOGIC		

NOTES/COMMENTS/QUESTIONS:

Form Completed by: <input type="checkbox"/> Patient <input type="checkbox"/> Office Nurse <input type="checkbox"/> Physician <input type="checkbox"/> Other	
SIGNATURE OF PATIENT:	DATE: