

Patient Information Sheet

Patient Name Patient Date of Birth Patient Social Security #

Street Address City, State & Zip code

Home Phone Cell Phone Work Phone

Email Address Pharmacy Address/Phone:

Patient Employer Address

Spouse Information

Spouse Name Spouse Date of Birth Spouse Social Security #

Spouse Employer Spouse Address (if different)

Spouse Cell Phone Spouse Work Phone

Emergency Contact Information

IN CASE OF EMERGENCY, NOTIFY: _____
Emergency Name (other than spouse)

Emergency Contact Address Emergency Contact Phone

Referral

Who may we thank for your referral? _____

Insurance Information

Insurance Information Payment is requested at the time of service, unless prior arrangements have been made

Insurance Company Name of Primary Insured

Authorization to Release Information and Assignment of Benefits

- By checking the box on the left, I certify that information I have reported about my insurance is correct.
- By checking the box on the left, I authorize the release of any medical information necessary to process this claim.
- By checking the box on the left, I authorize my doctor to apply for benefits on my behalf for covered services rendered by him or her, or by his or her order. I request that payment from my insurance company be made directly to my doctor or to the party who accepts assignment.
- By checking the box on the left, I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing by either me or my insurance company.
- By checking the box on the left, I understand that I am financially responsible for the charges not covered by my insurance.

Signature

Date

Patient Medical History & Physical

Patient Name _____
Date of Last Examination

Marital Status: Single Married Divorced Widowed

Education (circle highest grade completed) 6th 7th 8th 9th 1 2 3 4 or More
High School College

Occupation How Long? Previous Occupation

Doctors Notes

Are you legally disabled? Yes No _____
Describe Disability

Do you use tobacco now? Yes No In the past? Yes No

Type and daily amount of tobacco use? How long have/did you use tobacco?

Do you use alcohol now? Yes No In the past? Yes No

Type and daily amount of alcohol use? How long have/did you use alcohol?

Do you use recreational drugs? Yes No

Do you use exercise regularly? Yes No _____
Please describe your exercise routine

Do you use follow a special diet (e.g. low cholesterol)? Yes No _____
Please describe your diet regime

Are your periods regular? Yes No _____
Date of last period Any problems with your periods?

Family History

Relationship	Living?	Age or age at death	Describe any health problems or cause of death
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Ages of Brothers/Sisters List of Sibling Health Problems

Ages of Children(s) List of Children(s) Health Problems

Patient Name

Please check illnesses which have occurred in your blood relatives

Diabetes Heart Attacks Nervous Illness Breast Cancer Stroke High Blood Pressure Thyroid Problems Asthma/Hay Fever

Allergies (to medications)

Medications (include vitamins, oral contraceptives, dosages and any you recently discontinued)

Medications continued

What percentage of time do you take medications exactly as prescribed?

Health Maintenance (Please indicate the year you last had any of the following):

TB Skin Test

Pap Smear

Immunizations

Hepatitis B

Rubella

Eye Exam

Mammogram

Tetanus

Stool for Blood

Cholesterol

Proctoscopy

Urine Test

Influenza

Pneumovax

Surgeries, list type and year (include appendix, hysterectomy, biopsies, etc.)

Surgeries continued

Medical illnesses (e.g. diabetes, cancer, asthma, heart or kidney trouble, nervous disorder)

Medical illnesses continued

Main reason you are here

Main symptom(s)

Doctor's Notes: _____



BHRT Checklist For Women

Patient Name

Date

Email Address

Symptom(s) (please check)

- | | | | | |
|------------------------------|--------------------------------|-------------------------------|-----------------------------------|---------------------------------|
| Depressive Mood | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Memory Loss | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Mental Confusion | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Decreased Sex Drive / Libido | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Sleep Problems | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Changes / Irritability | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Tension | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Migraine / Severe Headaches | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Difficult To Climax Sexually | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Bloating | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Weight Gain | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Vaginal Dryness | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Hot Flashes | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Sweats | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Dry and Wrinkled Skin | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Hair is Falling Out | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Cold All The Time | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Swelling All Over The Body | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Joint Pain | <input type="checkbox"/> Never | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |

Family History

- | | | |
|---------------------|------------------------------|-----------------------------|
| Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Osteoporosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alzheimer's Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Acknowledgement for Consent to Use and Disclosure of Protected Health Information (PHI)

Use and Disclose of your Protected Health Information (PHI)

Your Protected Health Information will be used by Dr. David Fong or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information (PHI) may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

Please list others we may release your PHI to: _____

Please indicate below whether you agree to allow us to leave a detailed telephone message regarding your test results at any of the phone numbers you have listed.

Agree Deny

Patient Name

Date

Signature

Preventative Well Woman Exam

Based on American College of Obstetrics and Gynecology and insurance standards, preventative office visits are routine well patient evaluations. Preventative well woman exams consist of health history, medication history, a physical exam with breast exam, pap smear, bimanual uterine/ovary exam (as indicated), urinalysis, and routine blood work (as indicated).

If an abnormality is encountered or a pre-existing problem is addressed in the process of performing this exam, you may be charged an additional fee/co-pay based on your insurance benefits. All visit information is sent electronically to your insurance company and you will be responsible for any additional fees as determined by your insurance benefits.

Patient Name

Date

Signature

General Consent for Treatment

General consent to Treatment: By signing below, I, (or my authorized representative on my behalf) authorize Dr. David Fong and his staff to conduct any diagnostic examinations, tests, and procedures deemed necessary in my care. I authorize the provision of any medications, treatment or therapy necessary to effectively assess and maintain my health or diagnose and treat my illness or injury. I understand that it is the responsibility of Dr. Fong to explain the rationale for diagnostic tests or procedures, the available treatment options, common risks and benefits or procedures, and alternative treatment options.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended by Dr. Fong. I also understand that the practice of medicine is not an exact science and no guarantees have been made regarding the results of my evaluation and/or treatment.

Signature

Date

I understand that I choose to send correspondence such as family photographs or birth announcements to the office of Dr. David Fong, the photos contained in these items may be displayed in public areas in the office. I understand that I have the right to request the photographs be kept private and will include a request of privacy with the correspondence if privacy is desired.

Signature

Date

These consents remain active unless revoked in writing by patient or authorized representative.

**Cancellation Policy / No Show Policy
For Doctor Appointments and Surgery**

1. Cancellation / No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a \$50 fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand delays can happen; however, we must try to keep the other patients and Dr. Fong on time.

If a patient is 15 minutes past their scheduled time, we have the right to reschedule the appointment.

Similarly, we try our best to stay on schedule, although emergencies sometimes arise. If we are significantly delayed, or Dr. Fong needs to leave unexpectedly due to surgery or delivery, we will try to notify you beforehand. Please assist us by being on time for your appointment.

3. Cancellation / No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expense for the office. If surgery is not cancelled at least 10 days in advance, you will be charged a \$75 fee. This will not be covered by your insurance company.

4. Account Balances

We will require that patients with self-pay balances to pay their account balances to zero prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over \$100 must make payment arrangements prior to future appointments being made.

Patient Name

Signature

Date