Radiance OB-GYN
Women's Health Is Our Passion

Registration Form

Patient Name:_____

☐ Female ☐ Male Date of birth _____

Social Security #_____ Email_____

Address: _____ Apt / Unit _____

City _____ State_____ Zip Code_____

Mobile phone: _____ Home phone: _____

Consent to text (appointment reminders, test results, etc.) ☐ Yes ☐ No

Consent to leave detailed phone message (test results, etc.) ☐ Yes ☐ No

Preferred method of communication (circle one): mobile phone / home phone / email

Would you like Portal access? ☐ Yes ☐ No

Demographics

Language: ☐ English ☐ Spanish ☐ Japanese ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to specify

Race: ☐ American Indian or Alaska Native ☐ Asian

☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

☐ White ☐ Decline to specify

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How did you hear about us? ☐ advertising ☐ primary care ☐ specialist physician

☐ patient in practice ☐ hospital ☐ insurance company

Can we access your **Medication History** directly from pharmacy benefits manager? ☐ Yes ☐ No

PHARMACY: _____ PHONE: _____

Preferred Lab: _____ Imaging:_____

Emergency Contact

Name: _____ Phone Number:_____

Relationship: (circle) Spouse, partner, parent, friend, Other _____

Employment

Employer Name: _____

Employer Phone Number: _____

Usual occupation (current or most recent): _____

Usual Industry: _____

Insurance

Primary Insurance: _____ ID#_____

Group Name: _____ Group #_____

Subscriber's Name: _____ Date of Birth: _____

Secondary Insurance: _____ ID#_____

Group Name: _____ Group #_____

Subscriber's Name: _____ Date of Birth: _____

Primary / Referring Physician

Primary Care Physician: _____

Referring Physician: _____

I certify that I have read and agree to Radiance OB/GYN payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Radiance OB/GYN all money to which I am entitled for medical expenses related to the services performed from time to time by Radiance OB/GYN, but not to exceed my indebtedness to Radiance OB/GYN. I authorize Radiance OB/GYN to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 120 days of notification of the amount due will result in submission to an outside collection agency. A $10.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from Radiance OB/GYN by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to Radiance OB/GYN. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature Date / Time

New Patient Intake Form

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Medication Allergies: include any reactions ☐ NKDA (no known drug allergies)

_____

_____

Food Allergies:

_____

Current Medications, dosage and frequency (use back or separate page if necessary):

_____

_____

Vaccines: Have you received: Gardasil vaccine (against HPV)? ☐ Yes (3 doses) ☐ Yes (< 3 doses) ☐ No

Influenza vaccine? ☐ Yes, (**date**) _____ ☐ No

Tdap/Tetanus/Whooping Cough vaccine? ☐ Yes, (**date**) _____ ☐ No

Medical Problems

Chief Complaint (reason for the visit): _____

List any ongoing medical problems (Gynecological or other):

_____

_____

Gynecological History

Are you sexually active: ☐ yes ☐ No Current Method of Birth Control? _____

First day of your last menstrual period? _____

Date of last Pap smear? _____

Results of last Pap: ☐ Normal Pap smear ☐ Abnormal Pap Smear: _____ ☐ Negative HPV ☐ Positive HPV

Have you EVER had an abnormal Pap? ☐ Yes ☐ No Details: _____

Have you had treatment due to an abnormal Pap? ☐ Yes ☐ No If Yes, indicate when: _____

Have you ever had an STD/STI (disease/infection)? _____

History of ☐ colposcopy or ☐ LEEP or ☐ cryoablation Dates: _____

Age of 1st period: _____ Most recent bone density/results: _____

Most recent Mammogram/results: _____ Date of last Colonoscopy/results: _____

Duration of menstrual flow (days): _____ Monthly menses? Y / N

Flow: ☐ Light ☐ Moderate ☐ Heavy Cycle frequency (Ex: every 28 days): _____

Hormone replacement therapy? ☐ Yes ☐ No Age at menopause: _____

Obstetric History (Please fill in the blanks with details or check appropriate boxes)

_____ Total number of pregnancies
_____ Full term
_____ Premature
_____ Abortions Elective
_____ Abortions Spontaneous (miscarriages)
_____ Ectopic pregnancies
_____ Multiple births (twins)
_____ Total living children

Pregnancy #1
Date of Delivery _____ # of fetuses: _____ Birth Weight _____ Sex ☐ Male ☐ Female
Type: ☐ Full term (> 36 wks) ☐ Preterm (< 36 wks)
☐ Miscarriage ☐ Elective termination D &C? ☐ Yes ☐ No
Delivery: ☐ Vaginal ☐ Cesarean section
Gestational age at time of delivery (Ex: 9 weeks or 39 weeks): _____
Anesthesia: ☐ General ☐ Local ☐ Epidural ☐ Spinal ☐ None ☐ Other _____

Pregnancy #2
Date of Delivery _____ # of fetuses: _____ Birth Weight _____ Sex ☐ Male ☐ Female
Type: ☐ Full term (> 36 wks) ☐ Preterm (< 36 wks)
☐ Miscarriage ☐ Elective termination D &C? ☐ Yes ☐ No
Delivery: ☐ Vaginal ☐ Cesarean section
Gestational age at time of delivery (Ex: 9 weeks or 39 weeks): _____
Anesthesia: ☐ General ☐ Local ☐ Epidural ☐ Spinal ☐ None ☐ Other _____

Pregnancy #3
Date of Delivery _____ # of fetuses: _____ Birth Weight _____ Sex ☐ Male ☐ Female
Type: ☐ Full term (> 36 wks) ☐ Preterm (< 36 wks)
☐ Miscarriage ☐ Elective termination D &C? ☐ Yes ☐ No
Delivery: ☐ Vaginal ☐ Cesarean section
Gestational age at time of delivery (Ex: 9 weeks or 39 weeks): _____
Anesthesia: ☐ General ☐ Local ☐ Epidural ☐ Spinal ☐ None ☐ Other _____

Pregnancy #4
Date of Delivery _____ # of fetuses: _____ Birth Weight _____ Sex ☐ Male ☐ Female
Type: ☐ Full term (> 36 wks) ☐ Preterm (< 36 wks)
☐ Miscarriage ☐ Elective termination D &C? ☐ Yes ☐ No
Delivery: ☐ Vaginal ☐ Cesarean section
Gestational age at time of delivery (Ex: 9 weeks or 39 weeks): _____
Anesthesia: ☐ General ☐ Local ☐ Epidural ☐ Spinal ☐ None ☐ Other _____

Pregnancy #5
Date of Delivery _____ # of fetuses: _____ Birth Weight _____ Sex ☐ Male ☐ Female
Type: ☐ Full term (> 36 wks) ☐ Preterm (< 36 wks)
☐ Miscarriage ☐ Elective termination D &C? ☐ Yes ☐ No
Delivery: ☐ Vaginal ☐ Cesarean section
Gestational age at time of delivery (Ex: 9 weeks or 39 weeks): _____
Anesthesia: ☐ General ☐ Local ☐ Epidural ☐ Spinal ☐ None ☐ Other _____

Prior pregnancy complications: (Ex: gestational diabetes, pre-term labor, preeclampsia, Breech)
_____
_____
_____
_____

Past Medical History

Personal & Family - Have you or any of your relatives **ever** had the following:

Please include age of diagnosis

	Self	Mother	Father	Brother	Sister	Maternal GM	Maternal GF	Paternal GM	Paternal GF	Son/Daughter	Son/Daughter	Other	Other
Alcohol Abuse													
Alzheimer's Disease / Dementia													
Asthma													
BREAST CANCER													
Chronic Liver Disease &/or Hepatitis													
Chronic Obstructive Pulmonary Disease													
Cirrhosis													
COLON CANCER													
Congestive Heart Failure													
Depression / Anxiety													
Diabetes													
Dialysis													
Emphysema													
ENDOMETRIAL (UTERINE) CANCER													
Heart Attack													
High Cholesterol													
HIV Infection													
Hypertension													
Kidney Disease / Stone / Infections													
Mental Illness													
Osteoporosis													
OVARIAN CANCER													
Parkinson's Disease													
Prostate Cancer													
Seizures													
Sexually Transmitted Disease													
Stroke													
Tuberculosis													
OTHER CANCER:													
Other:_____													
Other:_____													

Social History

TOBACCO USE: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoker ☐ Chew Tobacco

Years of Smoking _____ # of Packs/Cigarettes _____

ALCOHOL USE: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy **Type:** Wine, Beer, Hard Liquor

DRUG USE: ☐ Current ☐ Past ☐ None Years of usage _____

Type: THC/marijuana, cocaine, IV drugs, other Details: _____

OCCUPATION: _____

List any current or prior hazardous work exposures: _____

EXERCISE LEVEL: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy **Type:** _____

DIET: ☐ Regular ☐ Diabetic ☐ High Carb ☐ Vegetarian ☐ Vegan ☐ Gluten free

Are you a Jehovah's witness? ☐ Yes ☐ No

Surgical History

Past Surgical History (please indicate **date of surgery**)

_____ Hysterectomy (removal of uterus +/ - cervix)

_____ Through large abdominal incision only

_____ Through small, laparoscopic incision only

_____ Through vagina alone

_____ Combined laparoscopic / vaginal approach

_____ One or both tubes and ovaries removed

_____ Bladder lift (anterior colporrhaphy) _____ check here if with mesh

_____ Correction rectal prolapse (posterior colporrhaphy) _____ check here if with mesh

_____ Urethral Sling (TOT or TVT)

_____ Breast implants: (please circle) saline or silicone _____ Breast reduction

_____ Mastectomy; give details: _____

_____ Cholecystectomy (removal of gallbladder)

_____ Appendectomy (removal of appendix)

_____ Thyroidectomy (removal of thyroid gland: (please circle) partial or complete

Please list any other surgeries and dates:

_____

_____

_____

New Obstetric Episode

Number of fetuses: _____ Pre-pregnancy Weight: _____

Father of Baby Name: _____ Phone: _____

Relationship (Ex: Husband, Domestic partner, etc.): _____

Pediatrician: _____

Menstrual History

First day of Last menstrual period: _____ Definite: ☐ Yes ☐ No

Monthly Menses: ☐ Yes ☐ No Frequency: every _____ days

Age at first menses: _____ On birth control at conception: ☐ Yes ☐ No

Genetic Screening and Infection History (Personal or Family History, Patient or Father of Baby)

Mother will be 35 years or older at Estimated Date of Delivery?	☐ Yes ☐ No
Thalassemia (Italian, Greek, Mediterranean, or Asian Background)	☐ Yes ☐ No
Neural Tube Defect (Meningomyelocele, Spina Bifida, Or Anencephaly)	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No
Down Syndrome	☐ Yes ☐ No
Tay-Sachs (eg. Jewish, Cajun, French-Canadian)	☐ Yes ☐ No
Canavan Disease	☐ Yes ☐ No
Sickle Cell Disease or Trait (African)	☐ Yes ☐ No
Hemophilia or Other Blood Disorders	☐ Yes ☐ No
Muscular Dystrophy	☐ Yes ☐ No
Cystic Fibrosis	☐ Yes ☐ No
Huntington's Chorea	☐ Yes ☐ No
Mental Retardation/Autism	☐ Yes ☐ No
If Yes, Was Person Tested For Fragile X?	☐ Yes ☐ No
Other Inherited Genetic Or Chromosomal Disorder: _____	☐ Yes ☐ No
Maternal Metabolic disorder (eg. Type 1 Diabetes, PKU)	☐ Yes ☐ No
Patient or baby's father had a child with birth defects not listed above?	☐ Yes ☐ No
Recurrent Pregnancy loss, or a stillbirth	☐ Yes ☐ No

Any Other Genetic History: _____ ☐ Yes ☐ No

Live with someone with TB or Exposed to TB ☐ Yes ☐ No

Patient or partner has a history of genital herpes ☐ Yes ☐ No

Rash or viral illness since last menstrual period ☐ Yes ☐ No

Prior GBS-infected child ☐ Yes ☐ No

History of STD, Gonorrhea, Chlamydia, HPV, Syphilis ☐ Yes ☐ No

History of HIV ☐ Yes ☐ No

History of Hepatitis ☐ Yes ☐ No

Other infection history: _____ ☐ Yes ☐ No

Hemoglobinopathy or Carrier ☐ Yes ☐ No

Other Structural birth defect: _____ ☐ Yes ☐ No

Recent travel outside of country: _____ ☐ Yes ☐ No

Signature: _____ Date/Time: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name (if applicable): _____ Social Security #: _____

I hereby request and authorize (name of current health care facility) _____

to release health care information of the patient named above to:

Radiance OB-GYN
3998 Vista Way
Suite C
Oceanside, CA 92056

Tel: 760-385-8008
Fax: 760-305-8068

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information pertaining to the following treatment, condition, or dates:

_____

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 *et seq.*, includes herpes simplex virus, human papilloma virus, genital warts, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results and HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient signature: _____ Date: _____

Guardian signature (if patient is minor): _____ Date: _____

Name of Guardian (Print): _____ Relationship to patient: _____