Rassetti Gynecology

Edwin R. Ramirez, M.D.
1801 Solar Drive, Suite 251, Oxnard, CA 93030
Telephone: 805-278-0190 Fax: 805-278-6291

PATIENT INFORMATION

(_____) _____ _____ _____ _____
Maiden Name | First Name | Middle Initial | Last Name | Date of Birth

Address_____ City_____ State_____ ZIP_____

Home Phone_____ Cell Phone_____ Work Phone_____

Social Security Number_____ Drivers License Number_____

Employer_____ Occupation_____

E-Mail_____ Gender: M F Marital Status: M S D W

Spouse Name_____ Referred to our office by_____

Primary Care MD: Name_____ Office Phone Number_____

Preferred Lab_____ Preferred Pharmacy_____

INSURANCE INFORMATION

Please give your card to the receptionist to copy, COPY MUST BE ON FILE

Primary Insurance_____ ID #_____ Group #_____

Subscriber Name_____ Date of Birth_____

Subscriber Social Security Number_____ Employer_____

Secondary Insurance_____ ID #_____ Group #_____

Subscriber Name_____ Date of Birth_____

Subscriber Social Security Number_____ Employer_____

IN CASE OF EMERGENCY

Name of local friend or relative _____

Relationship_____ Home Phone_____ Cell Phone_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I directly assign all medical benefits to Rassetti Cosmetic Gynecology Institute (Edwin Ramirez, MD) and understand that I am financially responsible for all charges, whether or not paid by my insurance company. I also understand that I am responsible for any and all collection fees that may be incurred. I authorize Dr. Ramirez to release all necessary information to secure payment of benefits. I further agree that a copy of this agreement shall be as valid as the original. I also give my permission for Edwin Ramirez MD, to provide my medical care, or the medical care of my dependent.

Patient/Guardian Signature_____ Date_____

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HISTORY AND PHYSICAL EXAMINATION

TODAY'S DATE_____

Patient Name: _____DOB:_____

Age: _____ Sex: _____ Ht: _____ Wt: _____

Reason for Consultation: _____

_____

Address: _____

City: _____State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email Address: _____

Occupation: _____ Employer: _____

Who referred you to Dr. Ramirez? _____

Who is your primary physician? _____

Are you taking any medications? _____

Are you allergic to any medications? _____

Family History

		Cause of Death	Age
Father	Living / Deceased		
Mother	Living / Deceased		
Number of Siblings	#living___/ #Deceased___		

Do you have a Family History of:

	Yes	No	If yes, which family member (indicate paternal or maternal
Heart Disease			
High Blood Pressure			
Diabetes			
Stroke			
Cancer			
If yes location:_____			
Thyroid Disease/ Cancer			
Other diseases			

Review of Your Body Systems: Do you have now or have you ever had any of the following?

	Yes	No	Please Explain
Anemia			
Arthritis			
Blood Transfusions			
Bowel Disorders			
Breast Disease			
Cancer			
Chicken Pox			
Diabetes			
DES Exposure			
Endometriosis			
Excessive Bleeding			
Gall Bladder			
H. Hernia/Peptic Ulcer			
Headache/ Migraine			
Heart Disease			
Hypertension			
Infertility			
Jaundice/ Hepatitis			
Kidney Disease			
Respiratory Disease			
Psych. Illness/Depression			
Seizure Disorder			
Skin Disease			
Thyroid Disease			
Urinary Infections			
Varicose Veins/ Phlebitis			

Past Surgical History:

Date	Procedure

Illness History (other than Surgical Procedures):

Date	Procedure

Tests: (give date last done)

Test	Year Performed	Not Sure	Never Done	Results
Pap Smear				
Breast Exam				
Mammogram				
Rectal exam				
Sigmoidoscopy				
Cholesterol				
Rubella				
Triglycerides				
Thyroid Profile				
Tetanus (DTP)				
Bone Density				
Other_____				

Menstrual Period: (if Apply)

Age Onset: _____ Problems with Breasts: _____

Date of Last Period _____ Unusual Vaginal Discharge: _____

Periods: Regular: ___ Irregular:___ Difficulty with Periods: _____

Pregnancies: (if Apply)

# of Children Born Alive: _____ # of Cesarean Sections: _____

# of Premature Births: _____ # of stillborns_____

# of miscarriages: _____ # of Abortions_____

Describe any complications: _____

_____

Your Personal Habits: (Do you?)

	Yes	No	Please Explain
Do you exercise regularly (3 to 4 times per week)?			
Do you use illegal drugs?			
Do you use alcohol?			
Were you ever a heavy drinker?			
Do you smoke?			
If ever, when did you stop?			
Do you have an eating disorder? Anorexia____ Bulimia___			
Have you ever been physically abused?			
Do you feel safe in your home?			
Any Concerns?			

My signature indicates that the above information is true and correct to the best of my knowledge.

Signature_____ **Date**_____

Patient Signature

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PERSONAL HEALTH INFORMATION

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care in your best interest.

We also want you to know that we support the full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak to a HIPPA compliance officer.

You have the right to review a privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____

Signature: _____ Date: _____

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Charges for Missed Appointments

Dear Patient,

Please be informed of our policy concerning charges for missed appointments as well as our three strikes rule. We take patient care seriously and if you are not making your appointments then we are not able to give the quality of care that is our standard at Rassetti Gynecology. If you have any questions regarding this information please feel free to contact the office manager/office administrator to have your issues addressed.

Sincerely,

Edwin Ramirez, MD

Strikes Rule

Rassetti Gynecology requires 24 hour notification of an appointment that needs to be cancelled or rescheduled. Patients will accumulate a "Strike" for every same day cancellation or no show. Each patient will be given a warning after their first strike. Each missed appointment or same day cancellation after the first strike will be charged a $40.00 fee which will need to be paid before the patient will be seen for any subsequent appointments. If the patient accumulates 3 "strikes", it is at the doctor's discretion to terminate care of the patient. A list of local physicians will be given to the patient and once a new physician is chosen the office staff will forward any pertinent records to the doctor's office of choice.

I, _____, agree to the above terms and conditions.
(Print Name)

Patient Signature: _____ Date: _____

PATIENT RECORD OF DISCLOSURES

Patient Name: _____ DOB: _____

I wish to be contacted in the following manner (**check all that apply**)

- ☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

- ☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

- ☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work address
- ☐ O.K. to fax to this number

- ☐ Other _____

_____

Signature: _____ Date: _____

For Office Use Only

Record of Disclosures of Protected Health Information

Date	Disclosed To	(1)	Purpose of Disclosure	By whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type key: T-Treatment Records; P-Payment Information; H-Healthcare Operations

(3) Method Disclosure was made: F-Fax; P-Phone; E-E-mail; O-Other