Los Gatos Comprehensive Women's Care

R. Michael Contro, M.D., F.A.C.O.G.
Mark A. Fierro, M.D., F.A.C.O.G.
Obstetrics and Gynecology, Infertility

PATIENT INFORMATION FORM

Name _____ Date ____/____/____

Address _____ City _____ ZIP _____

Home Phone _____ Age _____ Sex: M F Date of Birth ____/____/____

Cell Phone # _____ Email _____

Soc. Sec. No. ____-____-____ Marital Status: S M D W

Employer _____ Work Phone _____

Employer Address _____ Drivers License # _____

Occupation _____

Who Referred You _____

SPOUSE INFORMATION

Name _____ Date of Birth ____/____/____

Address _____ ZIP _____

Home Phone _____ Soc. Sec. No. _____

Employer _____ Work Phone _____

INSURANCE INFORMATION

Primary Insurance _____ Supplemental _____

Address _____ Address _____

_____ _____

ID/Policy No. _____ ID/Policy No. _____

Group No. _____ Group No. _____

Policy Holder: Self Spouse Parent Other Policy Holder: Self Spouse Parent Other

Name _____ Name _____

Address _____ Address _____

EMERGENCY INFORMATION

Contact (outside of your household) _____

Address _____ Day Phone _____

Allergies to any medications _____

PLEASE SEE OTHER SIDE

POS Reorder # 0015674

OFFICE PAYMENT POLICY

Payment for office examinations and treatment is requested at the time services are rendered, unless other arrangements have been made with the office manager.

We are happy to assist you in submitting your insurance claims, but please remember that insurance is a method of reimbursing you, the patient, for fees paid to the physician.
IT IS NOT A SUBSTITUTE FOR PAYMENT.

AUTHORIZATION FOR RELEASE:

I HEREBY AUTHORIZE the release of any and all information, acquired in the course of my examination/treatment, to my insurance company.

SIGNATURE _____

DATE SIGNED_____ /_____ /_____

FINANCIAL AGREEMENTS:

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE for all charges incurred during the course of my examination/treatment.

SIGNATURE _____

DATE SIGNED_____ /_____ /_____

I HEREBY AUTHORIZE and request the payment of medical benefits directly to R. MICHAEL CONTRO, M.D., MARK A. FIERRO, M.D., for medical services rendered to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

SIGNATURE _____

DATE SIGNED_____ /_____ /_____

Los Gatos Comprehensive Women's Care
15251 National Ave, Suite 106
Los Gatos, CA 95032

Los Gatos Comprehensive Women's Care
OB-GYN HISTORY

Name_____ Date_____

Age _____ Height_____ Wt._____

SPECIAL PROBLEMS OR SYMPTOMS

1. In the blank lines below, please describe any special problems or symptoms you would like to discuss with the doctor today:

_____

_____

_____

2. How long have you had this problem? ..... _____for 1 week _____for 1 month_____for 1 year_____over 1 year
3. Have you ever seen a doctor for this problem in the past? ..... ____Yes____No

IF YES: a. How did he diagnose your problem?_____

_____

b. How did he treat your problem?_____

_____

c. Did his treatment help you?..... ____Yes____No

PREVIOUS PREGNANCIES

Please give all the information in regard to your previous pregnancies by filling in the spaces below. If information is unknown, leave space blank. (Include Miscarriages)

SUMMARY OF PREVIOUS PREGNANCIES	FULL TERM	PREMATURE	ABORTIONS	NOW ALIVE	MULT. BIRTHS

NO	YEAR	PLACE OF CONFINEMENT	DUR. OF PREG-NANCY	DUR. OF LABOR	TYPE OF DELIVERY	BORN ALIVE?	WT. OF INFANT AT BIRTH	COMPLICATIONS		BOY OR GIRL
								MATERNAL	CHILD	
1										
2										
3										
4										
5										
6										
7										
8										

MENSTRUAL HISTORY: Check (✓) Yes or No. Fill in blanks where appropriate.

Last menstrual period started on_____ 20_____. Normal: Yes ( ) No ( )

Previous menstrual period started on_____ 20_____. Periods are Reg. ( ) Irreg. ( )

Menstruated for the first time at age of_____years.

Usual interval from the first day of one period to first day of next period,_____days.

If periods are irregular, the interval between periods ranges from_____to_____days.

Menstrual flow usually lasts_____days. Scanty ( ) Moderate ( ) Heavy ( ) Clots ( )

Pain with periods: None ( ) Mild ( ) Moderate ( ) Heavy ( ) Incapacitating ( )

Other symptoms with periods, PLEASE DESCRIBE._____

Do you have bleeding or spotting between periods? Yes ( ) No ( )

Do you have any difficulty with intercourse? Yes ( ) No ( ) Unsatisfactory ( )

Do you ever have any vaginal discharge? Yes ( ) No ( )

Have you ever had a pap smear? Yes ( ) No ( ) Date_____ Place_____ M.D._____

Have you had previous pelvic problems? Yes ( ) No ( )

If the answer is yes, please give DATE_____ DIAGNOSIS AND TREATMENT_____ Dr. or Hospital_____

MARITAL HISTORY:

Single ( ) Married ( ) Separated ( ) Widowed ( ) Divorced ( )

Number of years married_____ Married more than once? Yes ( ) No ( ) How many times?_____

Husband's age_____ Ht._____ Wt._____ Health_____ Occupation_____

Contraception currently used: None ( ) Diaphragm ( ) Condom ( ) Pills ( ) IUD ( )

Please answer by using a Yes or No:

DO YOU USE:

Laxatives?_____ If so, how often?_____

Alcoholic Beverages?_____ How much?_____ Number of years:_____

Tobacco?_____ How much?_____ Number of years:_____

Medication?_____ Explain_____

Other Drugs?_____ Types:_____ How much?_____ Yrs._____

Have you gained or lost weight without dieting or other methods?_____

If yes to above question, how much did you gain or lose?_____ State normal weight:_____

PAST ILLNESSES: Check (✓) each with appropriate answer. If yes, please insert year of illness.

Yes	No	When
	MEASLES	
	MUMPS	
	CHICKENPOX	
	GERMAN MEASLES	
	POLIOMYELITIS	
	RHEUMATIC FEVER	
	SCARLET FEVER	
	TUBERCULOSIS	
	ALLERGIES	
	DRUG SENSITIVITIES	
	BLOOD DISEASES	
	OPERATIONS	
	MONONUCLEOSIS	
	HEPATITIS	

Yes	No	When
	HEART DISEASE	
	KIDNEY DISEASE	
	EPILEPSY	
	MENTAL ILLNESS	
	HERPES	
	DIABETES	
	THYROID DISORDER	
	INJURIES	
	BLOOD TRANSFUSION	
	HIGH BLOOD PRESSURE	
	VARICOSE VEINS	
	SEXUALLY TRANSMITTED DISEASE	
OTHER		

FAMILY HISTORY: Check Yes or No and give relationship of family members with the following:

Yes	No	RELATIONSHIP
	CANCER	
	DIABETES	
	TUBERCULOSIS	
	HEART DISEASE	
	KIDNEY DISEASE	
	HIGH BLOOD PRESSURE	
	HAY FEVER OR ASTHMA	

Yes	No	RELATIONSHIP
	EPILEPSY	
	NERVOUS BREAKDOWN	
	GLAUCOMA	
	SEVERE DEAFNESS	
	BLOOD DISEASE	
	MENTAL DISORDER	
	MUSCULAR DISORDERS	

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests
- Taking and utilization of cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designee

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that R. Michael Contro, MD, Inc. will use and disclose my information for the purpose of treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory test, all of which the judgment of the attending physician or their assigned designee, may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to R. Michael Contro, MD, Inc. or benefits otherwise payable to me. I hereby authorize the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payer, auto accident insurers, or for work related injury, to my employer or designee and understand that I am financially responsible for charges not covered. I understand that patient records may be stored electronically and make available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug-related condition, alcoholism, psychiatric conditions, and/or infections diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

(OPTIONAL) If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and the _____ Health Department and appropriate counseling will be offered.

(OPTIONAL) MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to R. Michael Contro, MD, Inc.

I acknowledge that I have been given the R. Michael Contro, Inc. Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial:

_____

I certify that I have read and fully understand the above statements and consent to fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature Date

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Obstetrics and Gynecology, Infertility
15251 National Ave, Suite 106
Los Gatos, CA 95032
408-356-5111

CREDIT CARD ON FILE AGREEMENT

Los Gatos Comprehensive Women's Care has implemented a new credit card policy. Like many other practices and medical offices, we kindly request our patients for a credit card which may be used later to pay any balance that may be due on your bill. Co-pays are still due at the time of service. At registration and/or check-in, your credit card information will be obtained and kept securely until your insurance(s) has paid their portion and has notified us of the balance due, if any. At the next billing cycle you will be sent a statement outlining your responsibility. At that time you will have 30 days to provide your desired form of payment. If no payment is received, your card on file will be charged seven (7) days after the 30 day period from the billing date expires. You may call or email our office if you have a question about your balance. Questions regarding your balance can be emailed to billing@losgatoscwc.com.

By signing below, I authorize Los Gatos Comprehensive Women's Care to keep my signature and my credit card information securely on-file in my account. I authorize Los Gatos Comprehensive Women's Care to charge my credit card for any outstanding balances when due based on the terms above.

Visa □ MasterCard □ Discover □ American Express □

Name on Card (Print): _____

Cardholder Relationship to Patient: _____

Credit Card Number: _____

Exp. Date: ___/____ CVV: _____

Credit Card Holder's Signature: _____

Date: _____

☐Yes, I would also like to keep this credit card on file for copays, due at the time of service.

Los Gatos Comprehensive Women's Care
Appointment Cancellation Policy

If you need to cancel or reschedule an appointment we kindly request 24 hours notice. Failure to provide notice within this time frame specified above or failure to show for a scheduled appointment will result in a fee. Fee amounts vary.