

PATIENT INFORMATION

[] Southwest Women's Care, P.C. 16611 South 40th Street, Suite 180 Phoenix AZ 85048
[] Southwest Women's Care, P.C. 2204 South Dobson, Suite 202 Mesa, AZ 85202

[] Kimberly Balk, MD [] Robert Grayson, MD [] Laura Kimbro, DO [] Stephanie Mayes, MD
[] Jamal Mourad, DO [] Mo Vaziri, MD [] Amy Williamson, MD [] Richard Wilson, MD
[] T. Simpson, WHNP

PATIENT NAME: _____ HOME: _____ WORK: _____ CELL: _____

BILLING ADDRESS: _____ CITY, STATE, ZIP: _____

PERMANENT ADDRESS: _____ CITY, STATE, ZIP: _____

PATIENT SS#: _____ SEX M F BIRTHDATE: _____ AGE: _____

IS PATIENT: Single Married Other IS PATENT Employed Full-Time Student Part-Time Student Other

EMPLOYER (NAME, ADDRESS & PHONE #): _____

RESPONSIBLE PARTY: _____ HOME PHONE #: _____ BUSINESS PHONE: _____

RESP. PARTY SS#: _____ RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER

SPOUSE OR NEAREST RELATIVE (NAME, ADDRESS & PHONE #): _____

SPOUSE OR NEAREST RELATIVE EMPLOYER (NAME, ADDRESS & PHONE #): _____

REFERRING PHYSICIAN (NAME & ADDRESS): _____

(Or how did you hear about us)

PRIMARY CARE PHYSICIAN (NAME & ADDRESS): _____

IS INJURY RELATED TO AN ACCIDENT? NO YES Auto Accident Job Related Injury DATE OF INJURY: _____

WHAT ARE YOU BEING SEEN FOR TODAY: _____ FIRST DATE OF SYMPTOMS: _____

ALLERGIES: _____ ARE YOU PREGNANT: YES NO

INSURANCE INFORMATION

PRIMARY INSURANCE
INSURANCE CO. NAME: _____

INS. CO. ADDRESS: _____

POLICY HOLDER NAME: _____

RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____

POLICY #: _____ GROUP/CLAIM #: _____

POLICY HOLDER SEX: M F BIRTHDATE: _____

COPAY \$: _____ DEDUCT \$: _____ VERIFIED: _____

SECONDARY INSURANCE
INSURANCE CO. NAME: _____

INS. CO. ADDRESS: _____

POLICY HOLDER NAME: _____

RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____

POLICY #: _____ GROUP/CLAIM #: _____

POLICY HOLDER SEX: M F BIRTHDATE: _____

COPAY \$: _____ DEDUCT \$: _____ VERIFIED: _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize this physician/clinic to release information to my insurance company required in the course of my examination or treatment which could include HIV, communicable disease or drug abuse information.

AUTHORIZATION TO PAY:

I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any otherwise payable to me for services.

I understand that I am financially responsible for the charges not covered by my insurance.

SIGNED (PATIENT OR GUARDIAN, IF PATIENT IS A MINOR)

DATE

HIPAA Notice of Privacy Practices

Southwest Women's Care

16611 S. 40th Street, Suite 180
Phoenix, Arizona 85048
480-785-2100

2204 S. Dobson Road, Suite 202
Mesa, Arizona 85202
480-222-0699

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings: Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless Required by Law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Date: _____ Signature: _____ Print Name: _____

SOUTHWEST WOMEN'S CARE

Baseline/Dobson
2204 S. Dobson Rd. Suite 202
Mesa, Arizona 85202

Pecos/40th Street
16611 S. 40th Street, Suite 180
Phoenix, Arizona 85048

HISTORY & PHYSICAL

PATIENT NAME: _____ D.O.B.: ____/____/____ AGE: _____ DATE: ____/____/____
SINGLE: _____ MARRIED: _____ DIVORCED: _____ WIDOWED: _____ YOUR OCCUPATION: _____

OFFICE USE: _____ HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____

GYNECOLOGIC HISTORY

AGE AT FIRST MENSTRUAL PERIOD: _____ DATE OF LAST MENSTRUAL PERIOD: ____/____/____
HOW OFTEN ARE YOUR PERIODS? _____ HOW LONG DO YOUR PERIODS LAST? _____
IS YOUR MENSTRUAL FLOW LIGHT: YES NO MODERATE: YES NO HEAVY: YES NO
DO YOU HAVE PAINFUL PERIODS? YES NO DO YOU HAVE PELVIC PAIN OF ANY NATURE? YES NO

AGE AT MENOPAUSE: _____ ARE YOU ON HORMONE REPLACEMENT? _____
DO YOU TAKE CALCIUM SUPPLEMENTS? _____ WHAT TYPE AND HOW MUCH? _____
DO YOU EXERCISE REGULARLY? YES NO HOW OFTEN? _____
WHAT EXERCISE DO YOU DO? _____

DATE OF LAST PAP SMEAR: ____/____/____ ANY HISTORY OF ABNORMAL PAP SMEARS? YES NO
HPV YES NO WHEN? _____
WHAT TREATMENT DID YOU HAVE FOR ABNORMAL PAP? _____

ARE YOU SEXUALLY ACTIVE? YES NO DO YOU USE CONTRACEPTION? YES NO
IF SO, WHAT TYPE(S) AND NAME(S): _____
ANY HISTORY OF SEXUALLY TRANSMITTED DISEASE(S): YES NO IF SO, WHAT KIND: _____
WERE YOU TREATED: YES NO WITH WHAT MEDICATION: _____

DATE OF LAST MAMMOGRAM: ____/____/____ ANY HISTORY OF ABNORMAL RESULTS? YES NO
DO YOU PRACTICE SELF BREAST EXAMS? YES NO HOW OFTEN? _____

OBSTETRICAL HISTORY

NO. OF PREGNANCIES _____ NO. OF LIVING CHILDREN _____ MISCARRIAGES _____
NO. OF PREMATURE DELIVERIES (before 37 weeks) _____ NO. OF ABORTIONS _____
PLEASE LIST DETAILS:

YEAR	WEEKS GESTATION	WEIGHT	SEX	DELIVERY TYPE	COMPLICATIONS

SURGICAL HISTORY

PAST SURGERIES/HOSPITALIZATIONS	DATE	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHYSICIAN NOTES: _____

SOUTHWEST WOMEN'S CARE

PATIENT NAME: _____

DATE: ____/____/____

PAST MEDICAL HISTORY

DRUG ALLERGIES: _____

WHAT HAPPENS WHEN YOU TAKE THESE MEDICATIONS: _____

MEDICATIONS YOU ARE CURRENTLY TAKING, STRENGTH, DOSAGE: _____

CARDIOVASCULAR:

PRIOR MYCARDIAL INFARCTION YES NO CORONARY ARTERY DISEASE YES NO
CONGESTIVE HEART FAILURE YES NO ESSENTIAL HYPERTENSION YES NO
HYPERLIPIDEMIA YES NO MITRAL VALVE PROLAPSE YES NO
HEART DISEASE YES NO

ENDOCRINE:

DIABETES MELLITUS TYPE I YES NO DIABETES MELLITUS TYPE II YES NO
OBESITY YES NO THYROID DISORDERS YES NO
HYPERTHYROIDISM YES NO HYPOTHYROIDISM YES NO

RESPIRATORY:

ALLERGIC RHINITIS YES NO ASTHMA YES NO
ACUTE BRONCHITIS YES NO COPD YES NO

IMMUNE/OTHER:

HIV YES NO

GASTROENTEROLOGY:

ESOPHAGITIS CHRONIC REFLUX YES NO HEPATITIS YES NO

GENITOURINARY:

PYELONEPHRITIS YES NO URINARY TRACT INFECTION YES NO
RENAL DISORDERS YES NO RENAL FAILURE YES NO

MUSCULOSKELETAL:

OSTEOARTHRITIS YES NO LUMBAGO (LOW BACK PAIN) YES NO
OSTEOPOROSIS YES NO

PSYCHIATRIC:

ANXIETY DISORDERS YES NO DEPRESSION YES NO

NEUROLOGICAL:

STROKE SYNDROME (CVA) YES NO MIGRAINES YES NO

