# ATTENTION NEW PATIENTS

## WELCOME TO OUR OFFICE
## PLEASE BE AWARE OF THE FOLLOWING POLICIES:

**There is a charge of $30.00 for missed appointments, and appointments that have been canceled without a 24 hour notice.**

**There is a charge of $150.00 for canceled surgeries, and surgeries that have been canceled without a 72 hour notice.**

There is a charge of $15.00 per forms that are needed to be filled out. Example: disability, family leave.

*** If you are here as a new OB patient please be aware that we run toxicology tests (drug) on all our pregnant patients**

**If you are here for your annual exam, vaginal discomforts, or a new OB patient these test are routinely done:**

Chlamydia
Gonorrhea
Gardnerella
Trichomonas
Candida

* Before your exam, please inform the practitioner if you **do not** want the tests list above done so they may discuss the matter with you.

Be aware that these tests may not be covered by your insurance and we will bill you for these services you may also discuss this with your practitioner and office staff.

_____

Patient's signature

NOTICE TO CONSUMERS:
MEDICAL DOCTORS ARE LICENCED AND REGULATED BY THE MEDICAL BOARD OF CALIFORNIA 1800-633-2322 www.mbc.ca.gov

**PATIENT NAME** **DATE**

# NOTICE OF NONCOVERAGE

**YOUR INSURANCE/ PROGRAM MAY NOT PAY FOR EVERYTHING, EVEN SOME CARE THAT YOU**
**OR YOUR HEALTH CARE PROVIDER HAVE GOOD REASON TO THINK YOU NEED.**

I UNDERSTAND THAT MY INSURANCE MAY NOT PAY FOR EVERYTHING. YOU MAY ASK TO BE PAID NOW , BUT I ALSO WANT MY INSURANCE/PORGRAM BILLED FOR AN OFFICIAL DECISION ON PAYMENT. I UNDERSTAND THAT IF MY INSURANCE/ PORGRAM DOES NOT PAY, OR THAT I MAY NOT MEET THE QUALIFICATIONS FOR A PROGRAM, I AM RESPOSIBLE FOR PAYMENT.
I HAVE HAD ALL MY QUESTIONS ANSWERED AND UNDERSTAND THAT I MAY REVIEVE A COPY OF WHAT I HAVE SIGNED TODAY.

PAIENT'S SIGNATURE

# FRESNO WOMEN'S CARE

*Vasanth M. Vishwanath, M.D.*

**OBSTETRICS & GYNECOLOGY**

**7075 N. MAPLE, STE. 102**
**FRESNO, CA 93720**

**TEL: (559) 299-8800**
**FAX: (559) 299-9944**


Patient:
DOB:

## FINANCIAL AGREEMENT

**AUTHORIZATION FOR TREATMENT AND PAYMENT:**
I AUTHORIZE TREATMENT OF THE PERSON NAMED ABOVE AND AGREE TO PAY ALL FEES AND CHARGES FOR SUCH TREATMENT. I AGREE TO PAY ALL CHARGES FOR ME AND MEMBERS OF MY FAMILY SHOWN BY STATEMENTS, PROMPTLY UPON PRESENTMENT THEREOF, UNLESS CREDIT ARRANGEMENTS ARE AGREED UPON IN WRITING. CHARGES SHOWN BY STATEMENTS ARE AGREED TO BE CORRECT AND REASONABLE UNLESS PROTESTED IN WRITING WITHIN THIRTY DAYS OF THE BILLING DATE IN THE EVENT LEGAL ACTIONS SHOULD BECOME NECESSARY TO COLLECT AN UNPAID BALANCE DUE FOR MEDICAL SERVICES RENDERED TO MY FAMILY OR ME. I/WE AGREE TO PAY REASONABLE ATTORNEY FEES OR OTHER SUCH COST AS THE COURT DETERMINES PROPER.

IT IS AGREED THAT PAYMENTS WILL NOT BE DELAYED OR WITHELD BECAUSE OF ANY INSURANCE COVERAGE OR THE PENDENCY OF CLAIMS THEREON, AND ALL PROCEEDS OF INSURANCE ARE ASSIGNED TO THIS OFFICE WHEN APPLICABLE, BUT WITHOUT THEIR ASSUMING RESPONSIBILITY FOR THE COLLECTION THEREOF.

EXPRESS PAYMENT AUTHORIZATION:
IT'S CONVENIENT WE WILL AUTOMATICALLY DEBT YOUR CREDIT CARD/DEBIT CARD.
YOUR CREDIT CARD INFORMATION IS KEPT PRIVATE AND SECURE. PLEASE FILL IN INFORMATION BELOW.
I GIVE DR. VISHWANATH PERMISSION TO DEBIT MY CREDIT CARD/DEBIT CARD FOR BALANCE DUE.

TYPE OF CREDIT CARD _____ CREDIT CARD# _____

_____ _____
RESPONSIBLE PERSON / SIGNATURE DATE

Vasanth M. Vishwanath, M.D., F.A.C.O.G.
BOARD CERTIFIED OBSTETRICS & GYNECOLOGY

# PATIENT INFORMATION SHEET

PATIENT'S NAME _____ _____ DATE OF BIRTH _____

ADDRESS: _____ Zip Code _____

CELL # _____ PHONE # _____ MARRIED ☐ SINGLE ☐ SEPARATED ☐

PATIENT'S EMPLOYER: _____ SS # _____

SPOUSE NAME: _____ PHONE # _____

SPOUSE EMPLOYER _____ SS # _____

**RELATIVE WHOM WE CAN CONTACT IN EVENT OF EMERGENCY:**

NAME _____ PHONE #: _____

ADDRESS: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ☐ NO ☑ PLEASE LIST

**HAS ANY OF YOUR FAMILY MEMBERS EVER BEEN TREATED AT THIS OFFICE?**

PLEASE LIST _____

PERSONAL DR. _____ REFERRING DR. _____

**I PLAN TO MAKE PAYMENT OF MY MEDICAL EXPENSES AS FOLLOWS:**

CASH/CHECK ☐ CREDIT CARD ☐ MEDI-CAL ☐

INSURANCE INFORMATION: _____ EFFECTIVE DATE: _____

SUBSCRIBER'S NAME: _____ CERTIFICATE # _____ GROUP # _____

*Vasanth M. Vishwanath, M.D., F.A.C.O.G.*

BOARD CERTIFIED OBSTETRICS & GYNECOLOGY

## HIPAA Consent Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a Privacy Rule to help insure that personal health care 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 health care operations.

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

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care 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 done 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. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing.

_____

PATIENT'S SIGNATURE

7075 N. MAPLE STE 103 FRESNO, CALIFORNIA 93720 Phone # (866) 99-GO-EMT TELEPHONE (559) 299-8800

Fresno Women's Care
Vasanth Vishwanath, MD
7075 N Maple Ave. Ste 102
Fresno, CA 93720

# New Patient Obstetrics & Gynecology Form

Name: _____ DOB: _____ Age: _____ Date: _____

Primary Care Physician: _____ Telephone: _____

Pharmacy: _____ Pharmacy Address: _____

Do you take any prescribed medication(s)? ☐ Yes ☐ No List: _____

_____

Do you take any supplements, vitamins, or over the counter medication(s)? ☐ Yes ☐ No List: _____

_____

Are you allergic to any medication(s)? ☐ Yes ☐ No List/Reaction: _____

Have you ever had shots for the following? ☐ Tetanus, Diphtheria, Pertussis (aka Tdap/whooping cough) Date _____

☐ Measles, Mumps, Rubella (German Measles) ☐ Polio ☐ Hepatitis A ☐ Hepatitis B ☐ Varicella (chicken pox)

☐ Shingrix (50+yrs) ☐ Pneumo 13__23__ ☐ Gardasil (aka HPV vaccine): Did you complete the 3 part series? ☐Yes ☐No

Have you received the Influenza Vaccine this year? ☐ Yes ☐ No Date: _____

**FAMILY HISTORY** Are you adopted? ☐ Yes ☐ No (If yes, please skip this section)

**Have your parents, brothers, sisters or children had any of the following? If yes, who?**

| | YES | NO | | WHO | | YES | NO | | WHO |
|---|---|---|---|---|---|---|---|---|---|
| 1. | ☐ | ☐ | Alcohol/Drug Abuse | _____ | 7. | ☐ | ☐ | Mental illness | _____ |
| 2. | ☐ | ☐ | Severe Anemia | _____ | 8. | ☐ | ☐ | Heart Attack | _____ |
| 3. | ☐ | ☐ | Bleeding Problems | _____ | 9. | ☐ | ☐ | High Cholesterol | _____ |
| 4. | ☐ | ☐ | Diabetes | _____ | 10. | ☐ | ☐ | Stroke | _____ |
| 5. | ☐ | ☐ | Cancer? What Kind: | _____ | 11. | ☐ | ☐ | Birth Defect/genetic problems (i.e. sickle cell anemia, PKU, Tay Sachs): _____ | |
| 6. | ☐ | ☐ | High Blood Pressure | _____ | | | | | |

**MEDICAL HISTORY: Have YOU had problems with: (please circle when necessary)**

| | YES | NO | | | YES | NO | | | YES | NO | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | ☐ | ☐ | Food/Seasonal allergies | 12. | ☐ | ☐ | Heart disease/problems | 23. | ☐ | ☐ | Problems holding urine |
| 2. | ☐ | ☐ | Skin _____ | 13. | ☐ | ☐ | High cholesterol | 24. | ☐ | ☐ | Liver disease/hepatitis |
| 3. | ☐ | ☐ | Anemia | 14. | ☐ | ☐ | High blood pressure | 25. | ☐ | ☐ | Gallbladder disease |
| 4. | ☐ | ☐ | Cancer:_____ | 15. | ☐ | ☐ | Stroke | 26. | ☐ | ☐ | Stomach problems/ulcers |
| 5. | ☐ | ☐ | Diabetes: Type 1 or 2 | 16. | ☐ | ☐ | Psychiatric problems | 27. | ☐ | ☐ | Constipation/hemorrhoids |
| 6. | ☐ | ☐ | Thyroid disease | 17. | ☐ | ☐ | Depression | 28. | ☐ | ☐ | Back injury/pain |
| 7. | ☐ | ☐ | Headaches/migraines | 18. | ☐ | ☐ | Anxiety | 29. | ☐ | ☐ | Osteoporosis/arthritis |
| 8. | ☐ | ☐ | Seizures/epilepsy | 19. | ☐ | ☐ | Eating Disorder | 30. | ☐ | ☐ | Lupus/Thalassemia |
| 9. | ☐ | ☐ | Asthma | 20. | ☐ | ☐ | Urinary Tract Infection | 31. | ☐ | ☐ | History of blood transfusion |
| 10. | ☐ | ☐ | Tuberculosis or PPD+ | 21. | ☐ | ☐ | Interstitial Cystitis | 32. | ☐ | ☐ | Bleeding/clotting problems (unrelated to your period) |
| 11. | ☐ | ☐ | Lung disease: _____ | 22. | ☐ | ☐ | Kidney Problems | | | | |

## MENSTRUAL HISTORY

First day of last menstrual period: _____ Age of first period: _____

My periods are:

☐ Regular ☐ Irregular ☐ Painful / ☐ Light ☐ Moderate ☐ Heavy

My period comes every _____ days and lasts for _____ days.

Do you have bleeding between periods? ☐ Always ☐ Sometimes ☐ Never

If you are postmenopausal, have you had any vaginal bleeding since your last period? ☐ Yes ☐ No

Is this your first pelvic exam? ☐ Yes ☐ No

## PREGNANCY HISTORY

Number of:

_____ Elective abortions

_____ Miscarriages

_____ Fetal Demise/Stillbirth

_____ Cesareans (c-sections)

_____ Ectopic (tubal)

_____ Molar pregnancy

_____ Premature births (before 37wks gestation)

_____ Normal (vaginal) births

_____ Total number of pregnancies

_____ Number of living children

_____ Age at first delivery

Complications and/or comments about

these pregnancies?: _____

_____

_____

Date of last pregnancy or birth: _____

Are you breast-feeding? ☐ Yes ☐ No

## BIRTH CONTROL HISTORY

If you use birth control, what methods have you used?

☐ None

☐ Rhythm/natural family planning

☐ Withdrawal/ pulling out

☐ Condoms/ rubbers / diaphragm/ cervical cap

☐ Foam/ suppositories/ cream/ jellies

☐ Pill / Kind?:_____

☐ Transdermal patch

☐ NuvaRing

☐ Depo Provera injection

☐ Nexplanon / Date Inserted _____ Removed _____

What office/clinician inserted it? _____

☐ IUD / Circle: Paragard / Mirena / Skyla / Liletta

Date Inserted _____ Removed _____

What office/clinician inserted it? _____

☐ Tubal Ligation (BTL) Date: _____

☐ Essure Sterilization / HSG Done? ☐ Yes ☐ No

☐ Partner with Vasectomy

List any problems you have had: _____

_____

Current Method: _____

I'd like to change my method to:_____

X_____

**CLIENT SIGNATURE** **DATE**

X_____

**CLINICIAN/PHYSICAN** **DATE**

**HOSPITALIZATIONS/ SURGERIES (Please list all except for pregnancies)**

Year: _____ Reason:_____ Year:_____ Reason: _____

Year: _____ Reason:_____ Year:_____ Reason: _____

**ANY OTHER MEDICAL PROBLEMS/HISTORY (Please list all)**

_____

**PERSONAL/SOCIAL HISTORY & HABITS/LIFESTYLE:**

Are you working? If so what is your job title?: _____ Marital Status _____

Do/Did you use tobacco products ☐ Yes ☐ No Please circle: Cigarettes / Cigars / Vaping/ Chewing Tabaco / Other

Do you use alcohol? Please circle: Rarely or special occasion / Monthly / Weekly / Daily

Do / Did you use illicit/street drugs? Please list: _____ How Long? _____ Quit Date_____

Do you consider your diet healthy? ☐ Yes ☐ No / Do you exercise? ☐ Yes ☐ No Type/How often? _____

Do you ever make yourself vomit after you eat or do you take laxatives to lose weight? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No At what age did you begin having intercourse?: _____

How many sexual partners have you had in the past 3 months?: _____

Is/Are your partner(s) ☐ MALE ☐ FEMALE ☐ BOTH / Do you use condoms?: ☐ ALWAYS ☐ SOMETIMES ☐ NEVER

Does your partner have other sexual partners? ☐ Yes ☐ No ☐ Not sure

Are you currently, or have you been, in a relationship where you were threatened or made to feel afraid? ☐ Yes ☐ No

Have you ever been hit, slapped, kicked, pushed, or shoved by your partner? ☐ Yes ☐ No

Have you ever been forced or pressured to engage in sexual activity when you did not want to? ☐ Yes ☐ No

Have you ever been raped? ☐ Yes ☐ No If so, at what age:? _____ Was it reported to officials?: ☐ Yes ☐ No

Did you receive counseling? ☐ Yes ☐ No / Are you interested in a counseling referral today? ☐ Yes ☐ No

**GYNECOLOGICAL HISTORY**

Last Pap Smear? _____ Normal? ☐ Yes ☐ No Last Mammogram _____ Normal? ☐ Yes ☐ No

Abnormal Pap Smears ☐ Yes ☐ No When?: _____ Did you undergo? (circle): Colposcopy / Cryotherapy / LEEP

Last Bone Density _____ Last Colonoscopy _____ BRCA/Colaris/genetics testing _____

Have you ever been on hormone replacement therapy for menopausal symptoms? ☐ Yes ☐ No Type: _____

Any personal history of:

Sexually Transmitted Infection (STD)? Please circle & date: Gonorrhea____ / Chlamydia____/ Syphilis____/ Herpes____/ Warts____ / Trichomonas____ / HIV____ / Hepatitis B____ / Hepatitis C ____ /Pelvic inflammatory disease(PID)____

Pelvic tumor or fibroid ☐ Yes ☐ No / Endometriosis ☐ Yes ☐ No / Ovarian cysts ☐ Yes ☐ No / Infertility ☐ Yes ☐ No

Polycystic Ovarian Syndrome (PCOS) ☐ Yes ☐ No / Breast Problems ☐ Yes ☐ No List: _____

Any other gynecological history? List: _____

_____

**NEW OB HISTORY**

OBSTETRICAL HISTORY INCLUDING ABORTIONS (SPONTANEOUS, ELECTIVE, MISSED) AND ECTOPIC/TUBAL PREGNANCIES

| YEAR OF PREGNANCY | PLACE OF DELIVERY | DURATION OF PREGNANCY | TYPE OF DELIVERY | COMPLICATIONS OF MOTHER AND/OR INFANT | FETAL SEX | FETAL BIRTH WEIGHT |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Genetic History**

Have you, the baby's father, or any family member had any of the following:

- Down Syndrome? Genetic or chromosomal abnormality? If yes, please specify. _____
  _____
- Neural tube defect? If yes, who? _____
- Hemophilia or bleeding disorder? If yes, who? _____
- Muscular Dystrophy? If yes, who? _____
- Cystic Fibrosis? If yes, who? _____
- If you or the baby's father are of Jewish ancestry, have you ever been screened for Tay-Sachs disease? If yes, please specify. _____
- If you or the baby's father are of African ancestry, have you ever been screened for Sickle cell? If yes, please specify. _____
- Have you or the baby's father been screened for A-thalessemia or B-thalessemia? If yes, please specify.
  _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

# Risk Assessment for Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

*Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather*

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

| | | BREAST AND OVARIAN CANCER | SELF | FAMILY MEMBER | AGE AT DIAGNOSIS |
|---|---|---|---|---|---|
| Y | N | Breast cancer at age 50 or younger | | | |
| Y | N | Ovarian cancer | | | |
| Y | N | Two primary (unrelated) breast cancers in the same person or on the same side of the family | | | |
| Y | N | Male breast cancer | | | |
| Y | N | Triple negative breast cancer* (ER-, PR-, HER2- pathology) | | | |
| Y | N | Three or more HBOC-associated cancers at any age in the same person or on the same side of the family<br>HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer | | | |
| Y | N | Ashkenazi Jewish ancestry with breast, ovarian, pancreatic, or aggressive prostate cancer in the same person or on the same side of the family | | | |
| Y | N | Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain: | | | |

_____
Patient's Signature Date

**FOR OFFICE USE ONLY**

- ☐ Candidate for further risk assessment and/or genetic testing
- ☐ Information given to patient to review
- ☐ Follow-up appointment scheduled Date: _____

- ☐ Patient offered genetic testing:
  - ☐ Accepted
  - ☐ Declined

_____
Healthcare Professional's Signature Date

*For a better understanding of triple negative breast cancer, please ask your healthcare provider.
Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.MyriadPro.com/guidelines





MYRIAD®