Aronson & Rosenthal, M.D. Inc,
3440 Lomita Blvd #120
Torrance, CA 90505

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual can also request that confidential communication, whether telephone communication or correspondence, be directed to an alternate site such as the individual's office.

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

___ Home Telephone _____
___ Leave message with detailed information.
___ Leave message with call back number only.

___ Cell Number _____
___ Leave message with detailed information.
___ Leave message with call back number only.

In our efforts to decrease the utilization of paper and printing, we ask that you use the patient portal to access your records and print as necessary. We will provide you with an account number to access that portal.

___ Email Address: _____

I hereby consent to the release of Protected Health Information to the following individual(s): family/friends. I understand this authorization will be in effect until which time it is revoked.

1) _____

2) _____

3) _____

_____ _____
Patient Signature Print Name

_____
Date

My preferred pharmacy is _____
(Please provide name, address and phone number)

NEW PATIENT / UPDATE FORM - PLEASE PRINT

Updated:_____ Date:_____

_____ Marital Status:_____

(office use only) Age:_____

Patient Name_____
Last First M.I. Cell/Pager Number Home Telephone

Address _____
Number Apt. # City State Zip

_____
Social Security Number Driver's License Number Birthdate

Patient Employer _____
Name Occupation Work hours Business Telephone

Business Address _____
Number City State Zip

Policy Holder / Insured _____
Name Relationship Birthdate Home Telephone

Address _____
Number Apt. # City State Zip

Insured Employer _____
Name Occupation Business Telephone

Business Address _____
Number City State Zip

In Case of Emergency _____
Name Relationship Home Telephone

How did you find out about our office (**PLEASE SELECT ONLY ONE OF THE FOLLOWING**)

Doctor (name)_____ Friend / Relative (name)_____ Phone Book_____

Hospital_____ Insurance Book_____ Other (please specify)_____

I plan to make payment of my medical expenses as follows:

( ) Cash / Check / Credit Card ( ) Medi-Care ( ) Medi-Cal

Insurance Name:_____Phone Number_____Certificate Number_____

PCP Name & Phone Number:_____ Co-Payment_____

I authorize the release of any medical information necessary to process my claim with my insurance company. It is agreed that payment will be made within 30 days of the date(s) of service and will not be delayed because of any insurance coverage issues. I hereby authorize my insurance company to pay directly to Aronson & Rosenthal, M.D., Inc., the benefits of any payable for service(s) rendered. **I understand that I am responsible for all laboratory costs incurred should my insurance not be contracted with the laboratories utilized by this office. I further understand that failure to notify the office 24 hours prior to a scheduled appointment will result in a $40.00 administrative fee**. I have read and fully comprehend the above agreement.

_____ _____

Patient Signature Signature of Responsible Party

PATIENT FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical services, routine examinations, Biopsies, Ultrasounds, all infertility and any other screening ordered by the Doctor or staff.

I UNDERSTAND THAT WHILE MY INSURANCE MAY CONFIRM MY BENEFITS, CONFIRMATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT AND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.

I understand and agree that it is **MY RESPONSIBILITY** to know if my insurance has any deductible, copayment, co-insurance, out-of-network, prior authorization requirements, or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand that if my insurance requires a referral it is my responsibility to understand what that referral encompasses.

If I am a Medicare patient I need to provide both my Medicare ID card and my secondary insurance card. If I do not furnish my secondary card I will be responsible in full.

By my signature, I certify to have read the above statements and fully understanding my financial responsibility for all care rendered to me so long as I am a patient of this practice.

_____	_____	_____
Printed patient name	Patient or Guardian signature	Date

HEALTH QUESTIONNAIRE

NAME:_____ DATE:_____

WHAT IS THE REASON FOR TODAY'S VISIT? (PLEASE CIRCLE)
Pap Smear Birth Control Infection Bleeding Pregnancy Other_____

If you have a problem, how long have you had it? _____
Have you consulted anyone before for this problem? Yes No Name of Physician: _____

GYN SYSTEM REVIEW

When was your last period?_____How many days did it last?_____
How old were you when your periods started? _____ How often do they come?_____ How often do they last?_____
Do you have: Bleeding between periods? Yes No Bleeding after intercourse? Yes No Painful periods? Yes No
Do you take medication for your period? If so, what medication:_____
When was your last **PAP**? _____ If you have ever had an **abnormal pap**, when and how were your treated?_____
_____When was your last **Mammogram**?_____
Do you have a discharge? Yes No If yes, please describe nature of discharge and prior treatments:_____
_____
Do you take hormones? Yes No What kind and how often?_____
Have you ever had a **Sexually Transmitted Disease? (Gonorrhea, Chlamydia, Herpes, Warts)**_____

BIRTH CONTROL: (If you are using or have used birth control, please fill in below)

METHOD	DATE	BRAND	DOSE	REASON FOR STOPPING
Pill				
IUD				
Tubal Ligation				
Other				

OBSTETRIC HISTORY: (If **less** than 65yrs old, please fill in below)

Deliveries: Date	Wt. Gain	# of Months Pregnant	Length of Labor	Birth Weight	Sex of Baby	Complications

Miscarriages: Date	Length of Pregnancy	Treatment	Complications

Terminations of Pregnancy: Date	Length of Pregnancy	Treatment	Complications

YOUR PERSONAL PAST MEDICAL HISTORY: (Have **You** had any of the below? Please check and supply the year)

Abnormal Pap	_____	Heart Disease	_____	Pneumonia	_____
Anemia	_____	High Blood Pressure	_____	Gyn. Disease	_____
Asthma	_____	Intestinal Problems	_____	Blood Transfusion	_____
Cancer	_____	Kidney Problems	_____	Rheumatic Fever	_____
Diabetes	_____	Liver Disease	_____	Urinary Tract Inf.	_____
Epilepsy	_____	Migraines	_____	Stroke	_____
Gall Bladder Disease.	_____	Phlebitis	_____	Thyroid Problems	_____

Have you ever had a **Colonoscopy?** If so when_____ Have you ever had a **Bone Density Exam**? If so when_____

Have you recently had any of the following problems? (Please check all that apply)

Loss of Urine	_____	Cough	_____
Severe Headaches	_____	Breathing Problems	_____
Visual Changes	_____	Chest Pain	_____
Deafness	_____	Leg Cramps	_____
Nausea / Vomiting	_____	Missed Periods	_____
Trouble Swallowing	_____	Weight Gain/Loss	_____
Heartburn	_____	Change in Hair Growth	_____
Rectal Bleeding	_____	Leakage from Nipples	_____
Burning with Urination	_____	Lump in Breast	_____

FAMILY HISTORY (Does anyone in your family have any of the following? Please indicate who, i.e., father, mother, sister, brother... etc.)

Alcohol/Drug Abuse	_____	High Blood Pressure	_____
Psychiatric	_____	Kidney Problems	_____
Sugar Diabetes	_____	Stroke	_____
Glaucoma	_____	Thyroid Problems	_____
Heart Disease	_____	Tuberculosis	_____
Breast/Gyn Cancer	_____	Colon/Rectal Disease	_____
Epilepsy	_____	Liver Disease	_____

Your race/ethnicity is: (Please circle all that apply)
White Black Chinese Japanese Korean Cambodian Laotian Vietnamese Southeast Asia Filipino Hawaiian
Native American Middle Eastern Asian-East Indian Samoan Unknown Hispanic Other_____

PREVIOUS SURGERY:
Date Procedure Hospital Location Surgeon Complications

_____

_____

Have you ever been in the **HOSPITAL** for anything not yet discussed?
Date Hospital Locations Reason Duration Complications

_____

_____

Please provide the name(s) of any prescription medications, over the counter medications, herbs and/or vitamins you are currently taking: _____

_____

Are you **ALLERGIC** to any medications or **LATEX**? Yes No **If yes, please explain and include the name of the medication(s) and reaction:**

_____

_____

Do you **SMOKE**? Yes No How many a day? _____
Do you **DRINK?** Yes No How much a day? _____
Do you use **DRUGS?** Yes No How often? _____
Do you have a history of anxiety, depression or mental illness? Yes No _____
Do you have a history of trauma or violence? Yes No _____
Do you have a special diet? Yes No _____

Are there any other matters you wish to discuss?_____

_____

_____

_____

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Our Commitment to Quality Medical Care

Aronson & Rosenthal, M.D. are committed to providing you with high quality medical care. We participate in continuing medical education to keep our knowledge and skills current and strive to ensure that our patients receive high quality medical care from this practice.

We also understand that as a patient, you may at times have concerns or complaints about our services. We encourage you to communicate you concerns to us or our staff. **Please tell us if you have a complaint – we value your feedback.** Please tell us if you have questions about your care, suggestions to improve the delivery of health care in this office, or complaints about any aspect of your treatment. We appreciate being part of your health care team and *greatly* value your feedback.

If the above suggestions are not satisfactory, or for any reason, you may contact the Medical Board of California. We offer this NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800-633-2322 or www.mbc.ca.gov).

I have read and understand the options available to me in regards to my medical care. I understand that medical doctors are licensed and regulated by the Medical Board of California.

_____
Patient/Patients Representative Signature

_____
Patient/Patient Representative Name-Please Print

_____
Date