Rancho Obstetrics and Gynecology, Inc.
25395 Hancock Avenue, Suite 210 ✦ Murrieta, California 92562
(951) 600-7066 ✦ (951) 600-7783 FAX

Our Office ONLY ACCEPTS CASH, CREDIT, OR DEBIT for all payments
All Co-Pays are due at the time of Service

PATIENT INFORMATION (please PRINT & Complete ALL information)

Name: _____ Date of Birth: _____/_____/_____ Age:_____

Address: _____ City/State: _____ Zip _____

Driver's License # _____ SS # _____

Home Phone: (_____) _____ Employer: _____

Work Phone: (_____) _____ Occupation: _____

Cell Phone: (_____) _____ Referred By/ PCP _____

E-Mail: _____

RESPONSIBLE PARTY (INSURED INFORMATION)

Name: _____ Date of Birth: _____/_____/_____

Address: _____ City/State: _____ Zip _____

SS# _____ Relationship to Patient: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

EMERGENCY INFORMATION (nearest relative not living with you)

Name: _____ Phone: (_____) _____

INSURANCE INFORMATION: HMO ☐ PPO ☐ EPO ☐ POS ☐

Primary Insurance: _____ Secondary Insurance: _____

Insured's Name: _____ Insured's Name: _____

ID #: _____ ID #: _____

Date of Birth: _____ Date of Birth: _____

Primary or Family Doctor: _____ Phone # (_____) _____

Payment is expected at the time services are rendered.
Please remember that payment is your responsibility regardless of insurance.

- If you are a Medicare beneficiary, Medicare will be billed for you. You will be responsible for deductibles, all non-covered services, etc. according to Medicare guidelines.
- Please note for certain insurance carriers, routine exams & preventative care visits are not covered services.
- All Co-Pays are due at the time of the office visit.
- In the event we are contracted with your insurance company, we will bill for you. If we receive notification that you are not eligible for coverage, you will be responsible for all charges incurred.
- All balances not paid within 30 days of statement date are subject to a $10.00 late fee.

Authorization to Release Information for Insurance Purposes: I hereby authorize Rancho Obstetrics and Gynecology, Inc., Sissi Selinger, DO, to release any information acquired in the course of my examination/treatment. I have read and understand the above statement. I agree to comply with the financial policies of this office and am financially responsible for my account.

SIGNATURE: _____ DATE: _____

I hereby authorize payment of benefits to be made directly to Rancho Obstetrics and Gynecology, Inc., Sissi Selinger, DO, for services provided to me. I understand that I am financially responsible to Rancho Obstetrics and Gynecology, Inc., Sissi Selinger, DO for charges and/or services not covered by this agreement. This authorization will remain in effect until revoked in writing by the undersigned.

SIGNATURE: _____ DATE: _____

Rancho Obstetrics and Gynecology, Inc.
25395 Hancock Avenue, Suite 210 ✦ Murrieta, California 92562
(951) 600-7066 ✦ (951) 600-7783 FAX

NOTICE OF PRIVACY PRACTICES

To Our Patients :

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information
2. Lawsuits and similar proceedings in response to a court or administrative order
3. If required to do so by a law enforcement official
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, we will only made disclosures to a person or organization able to help prevent the threat
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities
6. To federal officials for intelligence and national security activities authorized by law
7. To correctional institutions or law enforcement, if you are and inmate or under the custody of a law enforcement official
8. For Workers Compensation and similar programs

Your rights regarding your health information

1. Communications: you can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information of only certain individuals involved in your care of the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your physician
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to your physician. You must provide us with a reason that supports your request for amendment
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy the Notice at any time
6. Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: **Privacy Officer, 25395 Hancock Avenue, Suite 210, Murrieta, CA 92562.** All complaints must be submitted in writing. You will not be penalized for filing a complaint
7. Right to provide an authorization for other uses and disclosures: our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law

---

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices.

Signature _____

Printed Name of Patient _____

Date _____

Rancho Obstetrics and Gynecology, Inc.
25395 Hancock Avenue, Suite 210 ✦ Murrieta, California 92562
(951) 600-7066 ✦ (951) 600-7783 FAX

Notification Consents

Patient's Name: _____

Date of Birth: _____

E-mail address: _____

Mobile Phone: _____

Home Phone: _____

Appointment Reminder Notifications

With my consent, I agree to receive appointment reminders and general notifications by automated phone call, e-mail or text message.

Indicate Preference: ☐ Phone Call ☐ E-mail ☐ Text Message

Signature of Patient _____ Date _____

Pap Results

With my consent, I agree to have results and a reminder for my next Pap smear emailed to me.

Signature of Patient _____ Date _____

(Please add our address: results@ranchoobgyn.com to your address book, or your e-mail may be sent to your junk/spam folder)

Rancho Obstetrics and Gynecology, Inc.
25395 Hancock Avenue, Suite 210 ✦ Murrieta, California 92562
(951) 600-7066 ✦ (951) 600-7783 FAX

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Rancho OB/GYN may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Rancho OB/GYN reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by making a written request to Privacy Office at 25395 Hancock Ave, Suite 210, Murrieta, CA 92562.

With my consent, Rancho OB/GYN may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, necessary insurance information, etc.

With my consent, Rancho OB/GYN may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, etc.

I understand that if I choose to be accompanied by any persons during my office visit, private medical information may be disclosed.

By signing this form, I am consenting to Rancho OB/GYN's use the disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Rancho OB/GYN may decline to provide treatment to me.

I give permission for Rancho OB/GYN to disclose protected health information (PHI) to the following persons.

Name:	Relationship:
_____	_____
_____	_____
_____	_____

_____ _____
Signature of patient or legal guardian Date

_____
Patient's Name

_____
Print Name of Legal Guardian

Consent for Treatment

1. I hereby do voluntarily consent to such care, including routine procedures and other treatment by professionals and their assigns, appointees or Consultants as is necessary in their judgment.
2. I am aware that the practices of medicine, surgery and other health disciples do not constitute exact sciences, I acknowledge that no guarantees have been made to me as the result of treatments or examinations.
3. I understand that for certain procedures deemed necessary by my physician, I will be required to sign a Special Consent Form. Furthermore, if I do not fully understand a procedure or its risks, consequences and alternate methods of treatment I have the right to question the appropriate professional.
4. I understand that Rancho OB/GYN shall not be responsible or liable for the loss of/or damage to any personal property.
5. I authorize the release to any party for my care, such information from my records as is required in order for Rancho OB/GYN and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and/or treatment records of psychological services and social services, including communications made by the patient to the physician, social worker, or psychologist. This authorization shall be effective so long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received.

I have read the above statement. I certify that I understand its contents.

Print Patient Name _____ Date of Birth_____

Signature of Patient_____ Date _____

Signature of Parent/Legal Guardian_____ Relationship_____

PATIENT HISTORY QUESTIONNAIRE

Rancho Obstetrics and Gynecology, Inc.
25395 Hancock Avenue, Suite 210 ✦ Murrieta, California 92562
(951) 600-7066 ✦ (951) 600-7783 FAX

OBSTETRICAL HISTORY

Date of your last normal period? _____

Are you sure of this date?..... ☐ Yes ☐ No
Were your periods regular?..... ☐ Yes ☐ No
Were you on birth control pills?..... ☐ Yes ☐ No
Date that you last used the "pill"? _____

Number of pregnancies? _____
Number of deliveries? _____
Number of miscarriages? _____
Number of abortions? _____
Number of living children? _____
Number of C-sections? _____
Reason for C-section? _____

Have you had any of the following problems with previous pregnancies?

Preterm labor (labor pains before the baby was due)?..... ☐ Yes ☐ No
Preterm delivery (more than 3 weeks before due date)?..... ☐ Yes ☐ No
Stillbirths (babies born dead)?..... ☐ Yes ☐ No
Fetal distress in labor?..... ☐ Yes ☐ No
High blood pressure, toxemia or preeclampsia?..... ☐ Yes ☐ No
Problems with the baby getting "stuck," or being hard to deliver due to large shoulders?..... ☐ Yes ☐ No
Diabetes in a previous pregnancy?..... ☐ Yes ☐ No
Any other problems with pregnancies?.. ☐ Yes ☐ No

GYNECOLOGIC HISTORY

What type of birth control did you use before getting pregnant?_____
At what age did your periods start? _____

Were your periods regular?..... ☐ Yes ☐ No
Have you had infertility problems?..... ☐ Yes ☐ No
Have you had pregnancy losses at 4-5 months or an "incompetent" cervix?..... ☐ Yes ☐ No
Do you have any abnormalities of the uterus (fibroids, double uterus, or septum, etc.)?..... ☐ Yes ☐ No
Have you had any surgery of the female organs (removal of fibroids, surgery on the tubes, ectopic pregnancy, cone biopsy of the cervix, etc.)?..... ☐ Yes ☐ No
Have you ever had an abnormal pap test, genital warts, or precancer or cancer of the cervix?..... ☐ Yes ☐ No

Comments _____
_____

BIRTH DEFECTS: Please include yourself, the baby's father and anyone in either family when you answer these questions.

Are you age 34 or over?..... ☐ Yes ☐ No
Family history of mental delay?..... ☐ Yes ☐ No
Family history of Down syndrome (mongolism) or any other genetic defects?.... ☐ Yes ☐ No
Do you, the baby's father, or one of your children have a birth defect such as the ones listed below? (*Circle any that apply*)..... ☐ Yes ☐ No

a. Brain: hydrocephalus, anencephaly
b. Spinal cord: spina bifida, meningomyelocele
c. Cleft lip or palate
d. Heart: hole in heart, abnormal valves, other problems
e. Intestinal abnormalities: gastroschisis, omphalocele, intestines outside of abdomen
f. Kidney or bladder abnormalities
g. Limb defects: extra fingers, fingers stuck together, other abnormalities of arms of legs

Comments _____
_____

In your family is there a history of:

Hemophilia..... ☐ Yes ☐ No
Cystic fibrosis..... ☐ Yes ☐ No
Muscular dystrophy..... ☐ Yes ☐ No
Huntington's chorea..... ☐ Yes ☐ No
Sickle cell disease or trait..... ☐ Yes ☐ No
Thalassemia (familial anemia in those of Italian, Greek, Mediterranean, or Asian background)..... ☐ Yes ☐ No
Other genetic diseases..... ☐ Yes ☐ No
Are you or the baby's father Ashkenazi Jew or French Canadian..... ☐ Yes ☐ No
Are you and the baby's father related (for example, cousins)..... ☐ Yes ☐ No

Comments _____
_____

Have you taken any of the following medications during this pregnancy?..... ☐ Yes ☐ No

a. Accutane
b. Lithium
c. Coumadin
d. Other blood thinners
e. Seizure medicines (name and dose):_____
_____

Have you taken any other medicines during this pregnancy?..... ☐ Yes ☐ No
If so, give names _____
_____

Have you had x-rays during this pregnancy? ☐ Yes ☐ No

PATIENT NAME _____

DOB _____

Rancho Obstetrics and Gynecology, Inc.
25395 Hancock Avenue, Suite 210 ✦ Murrieta, California 92562
(951) 600-7066 ✦ (951) 600-7783 FAX

PERSONAL HABITS

Many people who smoke, drink, or use drugs underestimate their usage; please be as accurate as possible in answering these questions. It is important that we know about any exposure to help us assess any possible risk to your baby.

Do you drink? …… ☐ Yes ☐ No
When did you last drink alcohol? _____
Number of drinks per day? _____
Do you smoke or vape? …… ☐ Yes ☐ No
How many packs per day? _____
Have you used drugs in the past? …… ☐ Yes ☐ No
If so, are you still using? …… ☐ Yes ☐ No
Please list drugs you have used or are using now (i.e. marijuana, cocaine, crack, ice, speed, PCP, etc.)

_____
_____

MEDICAL HISTORY

Do you have any of the following medical problems? (*Please check all that apply*) …… ☐ Yes ☐ No

- ☐ Diabetes
- ☐ Thyroid disorder
- ☐ Seizures or epilepsy
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Rheumatic fever
- ☐ Asthma
- ☐ Kidney disease
- ☐ History of blood transfusions
- ☐ History of blood clots
- ☐ Bleeding disorder
- ☐ Low platelets
- ☐ Lupus
- ☐ Anesthesia problems
- ☐ History of cancer
- ☐ History of phenylketonuria

Comments _____
_____

Do you have any allergies to medications? ☐ Yes ☐ No
If so, please list them: _____
_____
_____

SURGERY/HOSPITALIZATION HISTORY

Have you ever had surgery or been hospitalized for any reason (other than a normal delivery)? ☐ Yes ☐ No

If so, please list the dates and reasons below:

DATE	REASON

INFECTIOUS HISTORY

Please include yourself and your sexual partner when you answer these questions. Have you ever had any of the following:

History of herpes? …… ☐ Yes ☐ No
More than one sex partner in the last 5 years? …… ☐ Yes ☐ No
History of any sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts)? …… ☐ Yes ☐ No
History of hepatitis (yellow jaundice)? …… ☐ Yes ☐ No
History of/exposure to tuberculosis? …… ☐ Yes ☐ No
Rash with a fever during this pregnancy? …… ☐ Yes ☐ No
Do you think you are at an increased risk for AIDS (risk factors include blood transfusions, drug use, multiple sex partners, bisexual or homosexual activity)? …… ☐ Yes ☐ No

Comments _____
_____

FAMILY HISTORY

Do you have any medical problems in your family (immediate family or grandparents)? …… ☐ Yes ☐ No
Please check the problem and list who has it:

- ☐ Diabetes _____
- ☐ High blood pressure _____
- ☐ Heart disease _____
- ☐ Breast cancer _____
- ☐ Other cancers _____
- ☐ Twins _____
- ☐ Other _____

PROBLEMS IN THIS PREGNANCY

Please check any that apply:

- ☐ No problems
- ☐ Nausea or vomiting
- ☐ Bleeding from the vagina
- ☐ Burning or pain on urination
- ☐ Vaginal burning/itching
- ☐ Vaginal discharge (yellow or foul-smelling)
- ☐ Fever or rash

Do you have any other concerns?

_____
_____
_____

Signature _____ Date _____
Signature of provider reviewing history _____

PATIENT NAME _____

DOB _____

Rancho Obstetrics and Gynecology, Inc.
25395 Hancock Avenue, Suite 210 ✦ Murrieta, California 92562
(951) 600-7066 ✦ (951) 600-7783 FAX

PRESCRIPTION MEDICATION HISTORY CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that is required in an ePrescribe program. These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Rancho Obstetrics & Gynecology, Inc. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Rancho Obstetrics & Gynecology to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Print Patient Name Patient DOB

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient