Women's Integrative Health
Sieu P. Truong, M.D.
Samina Makani, M.D.
Obstetrics, Gynecology, & Fertility

PATIENT DEMOGRAPHICS
Please fill out as thoroughly as you can.

Date: _____

Patient Information

Full Name: _____
Date of Birth: _____ Age: _____
Sex:_____ Martial Status:_____
Address:_____
Phone Number:_____Email:_____
Preferred Pharmacy:_____
Primary Care Provider:_____
Referring Provider_____
Place of Birth: _____Ethnicity: _____
Religious/Cultural Considerations: _____

Emergency Contact Information

Full Name:_____
Relationship to Patient:_____
Phone Number_____
Address_____

Reponsible Party (If Different From Patient)

Full Name:_____ Date of Birth_____
Relationship to Patient_____ Phone Number:_____
Address_____

Primary Insurance Information **(we do not accept HMO insurances)**

Insurance Company:_____
Policy Number:_____ Group Number_____
Subscriber Name_____ Date of Birth: _____

Secondary Insurance Information **(we do not accept HMO insurances)**

Insurance Company:_____
ID or Policy Number:_____ Group Number:_____
Subscriber Name:_____ Date of Birth: _____

PATIENT HISTORY

FULL NAME:_____ DATE_____

Chief Reason for Today's Visit:

_____

_____

Past Obstetric History:

Any history of INFERTILITY problems?_____

Total Number of Pregnancies to date:_____

Of these pregnancies, how many were:

- Full-term pregnancies delivered (near to due date): _____
- Pre-term deliveries (before 37 weeks of pregnancy): _____
- Elective terminations:_____
- Ectopic pregnancies:_____
- Spontaneous Miscarriages:_____

Total Number of Twin/Multiple Pregnancies:_____

Total Number of Living Children Currently:_____

Details of Pregnancies:

Year Delivered	Length of Pregnancy	Duration of labor	Type of Delivery (Vag. Or C-section)	Infant (Sex/Wt.)	Complications D&C?,Now living?
1.					
2.					
3.					
4.					
5.					

Past Gynecological History:

Date of last menstrual period: _____ Are you sure of this date?_____

Age when first menstrual period began: _____

Last Pap Smear: _____ Was it normal?_____ Where done:_____

Last Breast Exam by a Dr. _____ Normal? _____

Last Mammogram: _____ Was it normal?_____ Where done:_____

My Menstrual Periods are: (Circle one)

REGULAR (once a month) or IRREGULAR (more or less than once a month)

- The interval between the onsets of one period to the onset of the next is____ days.
- Duration of menstrual flow is _____ days.
- Is the menstrual flow (circle one) Mild Moderate Heavy Severe
- Do you have problems with bleeding in between periods? _____
- Are menstrual periods painful?___ If yes, (circle one): mild moderate severe
- What do you take (or have you taken) for pain? _____
- Is intercourse usually painful? _____
- Have you ever been told you have endometriosis? _____

FULL NAME: _____ DATE:_____

Do you experience any of the following PMS (pre-menstrual syndrome) symptoms?

☐ Headaches	☐ Frequent urination	☐ Hot flashes
☐ Breast tenderness	☐ Night sweats	☐ Anxiety
☐ Irritability	☐ Depression	☐ Bloating

☐ Other: _____

Are your PMS symptoms: (circle one) mild moderate severe

Have you had any sexually transmitted disease in your life? (Circle below)

Gonorrhea Chlamydia Syphilis herpes HIV
Trichomonas Genital Warts Pelvic Inflammatory Disease

Have you ever been tested for HIV? ____ When was last test? _____
Are you bothered by vaginal discharge? _____ Foul-smelling? _____ Itching?_____
Ever had an abnormal pap smear result? _____ Explain, if yes _____
_____
Have any procedures been performed on your cervix? _____
What types of contraception have you and your partner(s) used in the present/past?

Diaphragm Condom IUD Tubal ligation Vasectomy
Depo-Provera shot Norplant Spermicides
Birth Control Pills: (list names) _____
_____

Did your mother take DES (diethylstilbestrol) during her pregnancy with you?_____

Past Medical History:

Have you ever been hospitalized? _____
Have you ever had a blood transfusion? _____
Have you had chickenpox? _____
What medical problems have you had in your life? (Circle)

Anorexia	Bulimia	High Blood Pressure	High Cholesterol
Asthma	Allergies	Frequent Urinary Infections	Heart Disease
Frequent Vaginal Infections		Diabetes	Kidney Infections
Lung Disorders		Hypothyroidism	Hyperthyroidism
Liver Disease		Cancer	Osteoporosis
Depression		Strokes	Anxiety
Panic Attacks		Suicide thoughts, attempts, or plans	Trauma/Accidents
Epilepsy		Mitral valve prolapse	Other

Past Surgical History:

Date of Operation	Type of Surgery	Hospital	Physician	Complications

FULL NAME: _____ DATE:_____

Medications or Vitamins/Minerals (currently taking)

_____
_____
_____
_____

Are you ALLERGIC to any medications?

Medications What is the reaction when you take it?

_____
_____
_____

Social History:

Do you use Tobacco? _____ How much daily? _____
Do you drink Alcohol? _____ How much weekly? _____
Have you ever used recreational drugs? _____
If yes, which ones? _____
(Marijuana, Cocaine, Heroin, Amphetamines, LSD, PCP, Others)
Marital Status: (circle one) Married Single Divorced Separated
Living together Widowed
Are you currently sexually active? _____
Occupation:_____

Family History:

Has anyone in your family has any of these diseases or other important diseases?
(List family member next to the associated disease(s)

1. Heart Disease
2. Cancer
    a) Breast Cancer
    b) Colon Cancer
    c) Uterine Cancer
    d) Ovarian Cancer
    e) Cervical Cancer
    f) Other Cancers
3. Osteoporosis
4. Diabetes (with or without insulin)
5. High Blood Pressure
6. Mental Retardation
7. Birth Defects (for example, spina bifida, cystic fibrosis, cleft palate)
8. Genetic Disease (for example: Tay-Sachs trait)
9. Psychiatric disorders (for example, alcoholism, depression, etc.)
10. Tuberculosis
11. Other family diseases?

FULL NAME:_____ DATE:_____

Symptom Review: (Circle any that apply to you)

Urine loss with cough or strain
Burning with urination
Vaginal discharge, with itching or foul odor
Fever
Night sweats
Chills
Milky or bloody breast discharge
Acne
Blood in stool or hemorrhoids
Frequent backaches
Recent weight change
Poor tolerance to cold temperatures
Bleed or bruise easily
Hot flashes
Insomnia
Other:_____

Constipation
Diarrhea
Nausea/vomiting
Frequent headaches
Chest pain
Shortness of breath
Excess hair growth
Hair Loss
Blood in Urine
Depression
Anxiety or Panic attacks
Dry Skin
Decreased sex drive
Vaginal dryness

ASSIGNMENT OF BENEFITS

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay full allowances for certain procedures, and others only pay a percentage of the charge.
PLEASE READ AND SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to **Women's Integrative Health / Sieu Truong, M.D. / Samina Makani, M.D**., and I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy / scan of this agreement shall be as valid as the original. Additionally,

- I understand that not all services are a covered benefit in all insurance contracts and some insurance companies arbitrarily select certain services that they will not cover.
- I acknowledge my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance company.
- I understand that copayments for office visits including telemedicine appointments are due at the time of service.
- I understand that deductibles are subject to collection prior to services being rendered.
- I understand that cash discounts will only be available at the time of office visit or, in the case of emergency procedures up until thirty days after the emergency procedure – after this time, the discount will be removed and I will be responsible to pay the full price charged.
- I understand that returned checks and balances older than 30 days will be subject to additional collection fees and interest charges.
- I understand that I will be a billed service charge for passing bad checks – service charges will be twenty-five dollars ($25) for the first bad check and thirty-five dollars ($35) for each subsequent check. I understand that if I pass a check on insufficient funds I will be liable for the amount of the check plus damages (Civil Code 1719). The law sets damages at three times the amount owed, but not less than one hundred dollars ($100) or more than one thousand five hundred dollars ($1500).
- I understand that a Well-Woman Exam / Annual Exam / Exam with Pap smear may not be covered by my insurance company (including Medicare) and, if not covered, I will be responsible for paying the full charge.
- I understand that any discounts previously offered will be removed if my account is sent to collections and I will then be responsible for all charges on my account.
- I will notify Women's Integrative Health of changes to my billing address and/or health insurance.

At this time we are **NOT in network with **CORE** through **United Health** Care OR any **HMO** insurances. This visit may be considered out of network and the charges to you as the patient may be higher. Some insurance companies arbitrarily select not to cover certain services.

Signature (Responsible Party):_____ Date:_____

AGREEMENT TO OFFICE POLICIES (Part 1)

NO SHOW/CANCELLATION POLICY: Patients who cancel or reschedule an appointment with less than **24 business hours' notice** or who do not arrive for their scheduled appointment will be charged a **no-show fee**. The fee is **$50 or $75**, depending on the type of appointment.

To provide the best care for all of our patients, we ask that you allow **up to one hour** for your visit. While we make every effort to stay on schedule, our providers may occasionally run behind due to medical emergencies or the additional time some patients require for complex or sensitive care. We appreciate your patience and understanding.

LATE ARRIVAL POLICY: We understand that unexpected delays, such as traffic or emergencies, can occur. Please allow extra travel time to help ensure you arrive on time for your appointment.

Patients who arrive more than **15 minutes late** without notifying our office may be considered a **no-show**. If you arrive after the 15-minute grace period, whether you are able to be seen will be at the discretion of your provider and will depend on the provider's schedule and patient care needs. If we are unable to accommodate your appointment, you may be asked to reschedule and may be subject to our cancellation/no-show policy.

APPOINTMENT REMINDER POLICY: Our office may provide appointment reminders via text message as a courtesy to our patients. Please note that these reminders are not guaranteed and may not be delivered or received due to factors outside of our control, including carrier issues, incorrect contact information, or technical disruptions.

It is the patient's responsibility to keep track of all scheduled appointments and to update their contact information with our office as needed. Failure to receive a reminder does not exempt a patient from our no-show or late policy.

FEES:

- I understand that there is a **$50 or $75 cancellation/no-show fee** if I miss my scheduled appointment or cancel/reschedule without providing at least **24 business hours' notice**. The fee is based on the length and type of my appointment.
- I understand that there is a **$20 fee** for my provider to complete forms on my behalf (e.g., disability, FMLA, school, or other non-medical forms).
- I understand that there is a **$30 fee** for copies of my medical records released directly to me when the request exceeds **30 pages**. This fee applies after our office has received a signed Authorization for Release of Medical Records and the records are prepared for release.

BALANCES: In order to provide efficient service and reduce billing delays, our staff may review and collect any outstanding balances at the time of your visit, when scheduling appointments, or during phone interactions. This may include copays, deductibles, or past due balances. If you have any questions about your account, we are happy to assist you.

SURGERY/PRE-OPERATIVE FEES: All required surgical fees due to our office are expected to be paid at the time of your pre-operative appointment unless other arrangements have been made with your physician and our office. You will be notified of any applicable pre-operative fees prior to your appointment.

Please note that these fees are for services provided by our office only and do **not** include charges from the hospital, surgical facility, anesthesia provider, pathology, laboratory, or any other third-party providers. Those fees will be billed separately.

TERMINATION OF PATIENT RELATIONSHIP:

1. Patients who miss **three (3) consecutive scheduled appointments without notice** will receive a written warning. Any additional no-shows following this may result in termination from the practice. We value appointment availability for all patients, and missed appointments limit access to timely care for others.
2. Patients with an outstanding balance will continue to receive regular billing statements. If the balance remains unpaid, the patient will receive two written notices (Letter 1 and Letter 2) regarding the outstanding account. If there is no response after reasonable attempts to contact the patient, including phone outreach, the patient may be discharged from the practice for non-payment.
3. Our office is committed to providing a respectful and safe environment for both patients and staff. Disruptive, abusive, or threatening behavior toward staff or providers will not be tolerated and may result in termination of care at the discretion of the practice.

By signing below, you acknowledge that you have read, understand, and agree to comply with all of the office policies listed above in Part 1 and Part 2 of our Agreement to Office Policies:

Signature: _____ Date: _____

HIPAA

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM FOR WOMENS INTEGRATIVE HEALTH

Printed Name: _____ **Date of Birth: ____/____/_____**

I have received a Notice of Privacy Practices **Initials _____**

Release of Information

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:(This includes your spouse, children, parents, grandparents and any care takers who can have access to this patient's records)

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

This ***Release of Information*** will remain in effect until terminated by me in writing.

Preferred contact method:

Home Phone #_____ Cell Phone #_____

Can we leave automatic appointment reminders on your home or cell phone?

Yes_____ or No_____

Can we send appointment reminders by text message to your cell phone?

Yes_____ or No_____

Can we leave a detailed message? Yes_____ or No_____

MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE, SHOULD I REQUEST MY MEDICAL RECORDS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

_____ _____

Print name Signature

_____ _____

Parent/Legal Guardian Date

**Doctor will not release Minor's medical information to parent without consent from minor, unless Minor's life or health is in jeopardy.

Sieu P. Truong, M.D.
Samina S. Makani, M.D.
Gynecology, & Fertility
477 N. El Camino Real Ste. C304, Encinitas, CA 92024
Ph: (760) 635-3777 **Fax:** (760) 942-7163

IMPORTANT INFORMATION REGARDING CHANGES FOR ANNUAL EXAMS

Insurance companies now dictate how physicians code and therefore bill for these services. There are two types that you need to be aware of that define office encounters, Preventive Physical Exams (Annual Exams) and Office Visits (Evaluation and Management Encounters, E&M Services)

- Preventive Physical Exams (Annual Exams)
  This is usually a visit/encounter to review preventative health issues such as:
  - Past Medical History
  - Interim medical history since last physical (including last colonoscopy/mammography)
  - Health habits/Diets
  - Abnormal bleeding
  - Pertinent Family History
  - Thorough physical exam including Pap Smear and necessary lab work
  - Birth control counseling

This visit **is not** designed to address specific complaints or to manage known medical problems. It's designed to educate you on changes you can make to live a healthier life and to identify potential health problems early.

- Office Visits (Evaluation and Management Encounters, E&M services)
  This encounter is designed for the evaluation and management of single or multiple complaints or disease processes (existing and/or new) such as:
  - High Blood Pressure
  - Thyroid problems
  - Decreased Libido
  - Insertion of IUD
  - Depression
  - Hormones/Menopause

If during your preventive physical exam, you and your physician decide to include management of your existing and/or any new medical problems, **you will likely be charged for both the preventative physical exam and the office visit.**
Depending on your insurance benefit, you may be required to pay the higher specialist copay and/or these charges may be applied to your out of pocket expenses such as deductible or co-insurance.
You will be responsible for any services rendered today that are not covered by your insurance carries. It is important for you to understand your individual insurance benefit coverage because each carrier processes claims differently.

Patients Name (Print): _____Date:_____
Patient's Signature:_____Date of Birth:_____

OPEN PAYMENTS NOTIFICATION

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

A copy of this notification can be made on request.

_____ _____

Print name Signature

_____ _____

Parent/Legal Guardian Date