Caring For Women Obstetrics & Gynecology

Emily Rekuc, D.O. | Chikanele Okorie, M.D. | Brandi Teegarden, FNP-C | Stephanie Townsend, FNP-C

Gynecology Office
79440 Highway 111, Suite 105
La Quinta, CA 92253

Obstetrics Office
81719 Dr. Carreon Blvd, Suite C-1
Indio, CA 92201

Patient Name: _____ Today's Date: _____
First MI Last

Date of Birth: ____/____/____ Marital Status: **S M D W (Please Circle)**

Address: _____
Mailing Address City State Zip Code

Home Phone: (_____) _____-_____ Cell Phone (_____) _____-_____

SSN: _____-_____-_____ Ethnicity/Race: _____

Employer: _____ Ph : (_____) _____-_____

Emergency Contact: _____ Relationship: _____ Ph : (_____) _____-_____

Pharmacy: _____ Address: _____

Primary Physician : _____ Phone: _____

EMAIL ADDRESS: _____

FOR APPT CONFIRMATION DO YOU PREFER AN EMAIL, TEXT OR BOTH? _____

PRIMARY INSURANCE

Name of Subscriber: _____ Birthdate: ____/____/_____
Relationship to Patient: Self Spouse Parent Other: _____

Insurance Co: _____ Subscriber #: _____

SECONDARY INSURANCE

Name of Subscriber: _____ Birthdate: ____/____/_____
Relationship to Patient: Self Spouse Parent Other: _____

Insurance Co: _____ Subscriber #: _____

RELEASE OF BENEFITS

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Emily Rekuc DO Inc. for medical services rendered to myself and/or my dependents. *I understand that I am responsible for any amount not covered by insurance in accordance with my insurance guidelines.*

Signature: _____ ***Date:*** _____

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize treatment, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment at Caring for Women.

Signature: _____ ***Date:*** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Caring for Women reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Caring for Women

***Name of Patient*:** _____ **(Please Print)**

Signature of Patient/Parent if Minor*:** _____ ***Date _____

Financial Policy and Insurance Information

I understand and agree that insurance claim forms will be submitted to my insurance company but that I am ultimately responsible for all charges regardless of my existing medical coverage. I hereby give authorization for payment of insurance benefits to be made directly to Caring for Women for services rendered. In the event that my insurance company forwards payment directly to me, instead of Caring for Women, I will immediately deliver said payment to Caring for Women. I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand and agree that if it becomes necessary for Caring for Women to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance (plus a $35 processing fee), and in addition, attorney fees, court costs and other expenses of litigation.

Co-Payments

Due to contractual obligations with your insurance company, all co-payments will be collected at the time of service. Co-payments are not billable and collection of co-payments is non-negotiable.

Completion of Forms

There is a charge for completing forms such as disability forms, DMV forms, or employer forms for various leaves. The Form Fee varies depending on the type of form however; the minimum fee is $35. The fee for this service is payable in advance of completing the form in ***cash only. Please allow 5-7 business days for completion of any form.***

Dr. Rekuc's Office Policy

I have reviewed a copy of Caring for Women Office Policies and have a clear understanding of these policies and expectations. I read the no show/excessive cancellation portion and understand that if I no show to 3 appointments that our doctor-patient relationship will end and I will have to obtain a new physician. I have reviewed and understand the above stated policies as indicated by my signature. By signing below, I am also stating that I am the person responsible for charges

Signature: _____ ***Date:*** _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or the staff of Caring for Women to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I **do not authorize** Caring for Women to release any or all information concerning my medical care to any individual except as set for above.

_____ I **do authorize** Caring for Women to verbally release any or all information concerning my medical care to the following individuals:

Name_____Relationship to Patient_____

Name_____Relationship to Patient_____

Name_____Relationship to Patient_____

Name_____Relationship to Patient_____

Signature: _____ Date: _____

Print Name _____ Date of Birth: _____

This release will remain in effect until rescinded/revised in writing by the patient.

Gynecologic Health History Questionnaire:

Name_____

Date of birth_____

Please describe what problem or concern brought you to our office today:

☐ Primarily to establish care ☐ Other (please briefly describe)_____

Special Communication Needs:		
Language preference:		If 'yes' to any of the questions below, how can we assist?
Visual impairment	☐ Yes ☐ No	
Hearing impairment	☐ Yes ☐ No	
Speech impairment	☐ Yes ☐ No	
Cognitive impairment	☐ Yes ☐ No	
Sensory impairment	☐ Yes ☐ No	

Personal Health History

Please check past or current problems or conditions

☐ Anxiety	☐ Bladder Problems
☐ Blood Disorder	☐ Heart Condition
☐ High Blood Pressure	☐ Liver Problems
☐ Hepatitis	☐ Neurological Condition
☐ Psychiatric Condition	☐ Depression
☐ Thyroid Disorder	☐ Lung Disorder
☐ Diabetes	☐ **Cancer**
☐ Breast Problems	Type: _____
☐ Kidney Problems	☐ Sexually Transmitted Disease
☐ Abnormal Pap Smears	☐ Other:_____
☐ Stomach Problems	☐ No Current Medical Conditions

Previous Surgical Procedures

Please check if you have had any of the following

Procedure	Year
☐ Breast Surgery	
☐ Hysterectomy Ovaries Rem.? ☐ Y ☐ N	
☐ Vascular surgery/stent	
☐ Spine Surgery ☐ Neck ☐ Back	
☐ Heart surgery	
☐ Other: _____	
☐ Joint replacement ☐ Hip ☐ Right ☐ Left ☐ Knee ☐ Right ☐ Left	

Gynecologic Health History

First day of last period: _____

Menstrual flow: ☐ Reg. ☐ Irreg. ☐ Pain/cramps

Days of flow _____ Time between periods_____

☐ Pain or bleeding after sex

☐ Vaginal bleeding/discharge

Menopause: ☐ Y ☐ N Age: _____

Birth control method _____

Obstetrical Health History

Number of pregnancies _____

Miscarriages_____

Pregnancy Term	Type of Delivery
	☐ Vaginal ☐ Cesarean
	☐ Vaginal ☐ Cesarean
	☐ Vaginal ☐ Cesarean
	☐ Vaginal ☐ Cesarean

Social History:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner **In a sexual relationship?** ☐ Yes ☐ No

Sexual Orientation: ☐ Heterosexual ☐ Bisexual ☐ Lesbian **Are you being sexually abused, threatened or hurt?** ☐ Yes ☐ No

Live here year round? ☐ Yes ☐ No If no, Part time location: _____

Occupation: **Concerns**: ☐ Stress ☐ Hazardous subst. ☐ Heavy lifting **Exercise:** ☐ No ☐ Yes: ____times/week

Tobacco use: ☐ Never ☐ Quit (when)_____ ☐ Current smoker: Packs/day, how many years_____

Alcohol use: ☐ No ☐ Yes If yes how many drinks/how often_____

Caffeine use: ☐ No ☐ Yes If yes, ☐ Coffee ☐ Soda ☐ Tea how many drinks/how often_____

Illicit Drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current
Describe:_____

Family History

Specifically, have any of your relatives had the following conditions:

Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	
☐ Diabetes		☐ Stroke	
☐ Thyroid Disease		☐ Arthritis	
☐ Pituitary Disease		☐ Dementia	
☐ Chrohn's/Colitis		☐ Cancer: ☐ Breast	
☐ Heart Disease < 65 years of age		☐ Colon	
☐ Hypertension		☐ Ovarian	

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations	Last Occurrence	Tests	Last Occurrence
Influenza vaccine ☐ Yes ☐ No		Mammogram ☐ Yes ☐ No	
Gardasil (HPV) vaccine rec'd ☐ Yes ☐ No		Pap smear/pelvic ☐ Yes ☐ No	
		Colonoscopy ☐ Yes ☐ No	
		Bone Density ☐ Yes ☐ No	

Hospital Admissions (excluding pregnancies):

Date	Hospital	Reason for admission

ALLERGIES: Please list *any* allergies to medications, foods, or materials (including latex)

Name	Symptom/Reaction

Medications:

Please list any medications that you take including over the counter medications, herbs, and supplements.

Name	Dose	Freq.	Name	Dose	Freq.

Pharmacy: _____ **Phone:** _____ **Store #:** _____

Location Description: _____

Additional Providers:

Primary Care Provider

Name: _____

Phone: _____ Last Seen: _____

Other: _____

Name: _____

Phone: _____ Last Seen: _____

Patient/Guardian Signature: _____ Date: _____

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Cancer Risk Assessment Questionnaire

_____ _____/_____/_____ _____/_____/_____

Patient Name Date of Birth Date Completed

This is a screening tool for the common features of hereditary cancer. Our service will allow us to give you the most technologically advanced screening possible to increase the chances of cancer detection and early intervention to optimize your health.

Circle Y for those that apply to YOU and/or YOUR FAMILY (consider 1st/2nd degree relatives on both mother's and father's side).
YOU AND THE FOLLOWING CLOSE BLOOD RELATIVES SHOULD BE CONSIDERED: ***Mother, Father, Sister, Brother, Sons, Daughters, Half-Siblings, Aunts, Uncles, Grandparents, Nieces, and Nephews***

		TYPES OF CANCER	RELATIONSHIP TO FAMILY MEMBER w/ CANCER and AGE at DIAGNOSIS		
			SELF/ SIBLING	MOTHER or Relatives on MOTHERS's side	FATHER or Relatives on FATHER's side
		EXAMPLE:	Me 55 Sister 40	Aunt 35	Grandmother 45
Y	N	Do you have a relative (s) with Breast cancer **before age 50?**			
Y	N	• Two breast cancers; one must be **50 or younger** (must be on same side of family to qualify) • Three or more breast cancers; they can be at **any age** (must be on same side of family to qualify)			
Y	N	Do you have a relative with Ovarian cancer **at any age**?			
Y	N	Do you have a relative with Male breast cancer **at any age**?			
Y	N	Ashkenazi Jewish ancestry ***with*** breast or ovarian cancer in a ***family member*** **at any age**?			
Y	N	Do you have a relative with Colon Cancer **before** Age 50?			
Y	N	Do you have a relative with Endometrial/ Uterine Cancer **before** Age 50?			
Y	N	Do you have a relative with Pancreatic Cancer **at any age?**			
Y	N	Do you have **Ten or more** lifetime colon polyps? (only applies to non-Medicare patients)			
Y	N	Any other cancers?			

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ☐ Yes ☐ No ☐ Do Not Know

Patient signature: _____ Date: _____

For Office Use Only:

Patient offered testing ☐ Accepted ☐ Declined Reason for decline: _____

☐ Does Not Meet Criteria ☐ Sample Collected

Office Signature_____

Caring for Women
Emily Rekuc, D.O.
79440 Highway 111 Suite 105
La Quinta, California 92253
Phone: (760) 777-4067 Fax: (760) 777-4096

New OB Intake Questionnaire

1. What was the date of your last menstrual period? _____
2. At what age did you have your first period? _____
3. Were you getting monthly periods?_____Every 28 days or 30 days? How many days is your period? _____ Flow? Heavy, Moderate, or Light? _____
4. Is this a planned pregnancy? _____If NO, Were you using any birth control?_____
5. How many children have you had? ___ Same father of baby?_____
6. When was your last pap smear? _____Normal or Abnormal?
7. Are you interested in any genetic testing?_____
8. Have you ever tested positive for TB?_____
9. Have you ever had any STDs, Hep B, Or Hep C?_____
10. Have you ever had chicken pox?_____
11. Do you need a prescription for prenatal vitamins?_____
12. Are you having any nausea or vomiting?_____
13. Have you had any feelings of depression?_____

Genetic Screening includes Patient, Baby's Father, or anyone in either family with :

Yes/No: 1. Patient's Age 35 years or older as of Estimate Date of Delivery

Yes/No: 2. Thalassemia (Italian, Greek, Mediterranean or Asian Background) MCV Less than 80

Yes/No: 3. Neural Tube Defect (Meningomyelocele, Spina Bifida or Anencephaly)

Yes/No: 4. Congenital Heart Defect

Yes/No: 5. Down Syndrome

Yes/No: 6. Tay-Sachs (Ashkenazi Jewish, Cajun, French Canadian)

Yes/No: 7. Canavan Disease (Ashkenazi Jewish)

Yes/No: 8. Familial Dysautonomia (Ashkenazi Jewish)

Yes/No: 9. Sickle Cell Disease or Trait (African)

Yes/No: 10. Hemophilia or Other Blood Disorder

Yes/No: 11. Muscular Dystrophy

Yes/No: 12. Cystic Fibrosis

Yes/No: 13. Huntington's Chorea

Yes/No: 14. Mental Retardation / Autism (If Yes, was person tested for Fragile X?)

Yes/No: 15. Other inherited genetic or chromosome disorder

Yes/No: 16. Maternal Metabolic Disorder (EG, Type 1 Diabetes, PKU)

Yes/No: 17. Patient or Baby's Father had a child with birth defects (not listed above)

Yes/No: 18. Recurrent Pregnancy loss or stillbirth

Yes/No: 19. Medications (Including supplements, vitamins, herbs or OTC Drugs) / Illicit / Recreational Drugs / Alcohol since last menstrual perioz