Bakersfield Neuroscience & Spine Institute
FINANCIAL POLICY

Thank you for choosing Bakersfield Neuroscience & Spine Institute. Our practice is committed to providing you with the highest possible care. Your clear understanding of our financial policy is important to our professional relationship. We will require that you read and sign our financial policy prior to any treatment.

INSURANCE

- If you are covered by insurance we will be happy to submit a claim for you if all necessary information is provided. Payment is subject to eligibility at time of service. Your insurance is a contract between you, your employer, and the insurance company. It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.
- If you have a managed care medical insurance that we participate with, your payment of deductibles, non-covered services and co-payments are due when services are rendered.
- We accept assignment from the Medicare program. You will be responsible for your annual deductible and the 20% of the allowable charges. Secondary insurance will be billed as a courtesy if information is provided.
- If you are covered by a government sponsored program you must present your current month medical card prior to services being rendered. If your card is not available, and we are unable to verify your eligibility, services will be considered self-pay.

INDUSTRIAL PATIENTS

Your worker's compensation carrier is responsible for your medical expenses. Please provide us with complete information and make sure that authorization has been received prior to services being rendered.

CASH PATIENTS

Payment is required at time of service if you do not have health insurance. **Medical-legal consultations** are also considered cash pay and payment arrangements must be made in advance. Attorney information must be provided if applicable. Fees related to consultations will cover time associated with reports and review of records.

FEES

Fees for medical services are based on the complexity of the problem and the amount of time required for the visit. We charge what is usual and customary for our area.

Additional fees:

- $10 service fee if copay is not paid at time of service
- $25 service fee on any returned checks
- $35 fee for missed appointments or failure to provide 24-hour notice of cancellation.
- Medical Records & Form Completion: Charges will not exceed the allowable for this service and are due at time of completion. Please inquire regarding fees at time of your request.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

______________________________ ____________________

Patient or Responsible Party Date

Notice of Privacy Practices

Bakersfield Neuroscience & Spine Institute

2601 Oswell Street, Suite 101, Bakersfield, CA 93306

Privacy Official (661-872-9999)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Official.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you. If a collection agency is utilized to obtain reimbursement, the necessary information will be provided to the agency handling your account.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you to other health care providers, health care clearinghouses, and health plans with whom we participate.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular address. We will review all reasonable requests submitted in writing which specify how or where you wish to receive these communications, and will notify you of our decision.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can

disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and will offer you a copy at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Bakersfield Neuroscience & Spine Institute

2601 Oswell Street, Suite 101, Bakersfield, CA 93306

I hereby acknowledge that I have been provided with a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: ______________________________ Date: __________________________

Print Name: __________________________ Telephone: _____________________

If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: ____

<u>For Office Use Only</u>: Acknowledgment Tracking Information

Name of Patient: ____

Date of Birth: ______________________________

Date patient received acknowledgement: ____________________ ***Staff Initials*** __________

Complete the following only if the Patient refuses to sign the Acknowledgment. Document efforts to obtain.

Date	Explanation/Reason	Staff Initials
____________	____	__________
____________	____	__________
____________	____	__________
____________	____	__________
____________	____	__________

Notice of Privacy Practices Acknowledgment Tracking Information

Name of Patient: ____

Date of Birth: ____________________________________

For Office Use Only:

Date patient received acknowledgement: ______________________________

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain (include dates, reason for refusal, staff initials)

____

____

____

____

____

____

SIGNATURE ON FILE

Insurance Authorization / Assignment

I authorize the release of any medical or other information necessary to process my insurance claim. My signature authorizes payment of all medical and/or surgical benefits, to which I am entitled to **Bakersfield Neuroscience & Spine Institute.** I understand that I am responsible for charges not covered by my insurance. A photocopy of this document is considered as valid as the original.

Patient Name/ (Print) ____________________ Date ____________________

Insured's Signature ____________________ Subscriber's Number ____________________

MEDICARE

Medicare Authorization / Assignment

I request that payment of authorized Medicare benefits are made on my behalf to **Bakersfield Neuroscience & Spine Institute,** for any services furnished me by Bakersfield Neuroscience & Spine Institute. I authorize any holder of medical information about me to the healthcare Financing Administration and its agencies any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA-1500 claim for or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Patient Name/ (Print) ____________________ Date ____________________

Insured's Signature ____________________

Patient's Medicare Number ____________________

Medigap Assignment of Benefits

I request the payment of authorized Medigap benefits be made either to me or on my behalf to **Bakersfield Neuroscience & Spine Institute** for any services furnished my by Bakersfield Neuroscience & Spine Institute. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits payable for related services.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient Name/ (Print) ____________________ Date ____________________

Patient's Signature ____________________

Medigap Number ____________________

Bakersfield Neuroscience & Spine Institute Date ______________________

2601 Oswell Street, Suite 101, Bakersfield, CA 93306

PATIENT REGISTRATION FORM (Please Print)

Our office policy requires that this form be updated on an annual basis.

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE:
RESIDENCE ADDRESS:		
MAILING ADDRESS:		
CITY:	STATE:	ZIP CODE:
DATE OF BIRTH:	SS#:	SEX: M / F
EMPLOYER:	EMPLOYER ADDRESS:	
HOME PHONE:	WORK PHONE:	CELL PHONE:

SPOUSE INFORMATION (Parent/Responsible Party for Child)

LAST NAME:	FIRST NAME:	MIDDLE:
DATE OF BIRTH:	SS#	CELL PHONE:
EMPLOYER:		WORK PHONE:

EMERGENCY CONTACT

NAME:	RELATION:	PHONE:
NAME:	RELATION:	PHONE:

PRIMARY INSURANCE *(Provide copy of card)*

INSURANCE NAME:		
ADDRESS:		
CITY:	STATE:	ZIP CODE:
GROUP/POLICY#:	PHONE:	
POLICY HOLDER:	SS#	

SECONDARY INSURANCE *(Provide copy of card)*

INSURANCE NAME:		
ADDRESS:		
CITY:	STATE:	ZIP CODE:
GROUP/POLICY#:	PHONE:	
POLICY HOLDER:	SS:	

WORKER'S COMPENSATION Yes No PLEASE ASK FOR ACCIDENT FORM

Consent for Medical Treatment: I hereby consent to routine diagnostic procedures and medical treatment by this provider. I understand that no guarantee of results has been made. I authorize Bakersfield Neuroscience and Spine Institute to render reasonable and proper medical care by current standards.

______________________________ ______________________

Signature of Patient/Responsible Party Date

I herby authorize Bakersfield Neuroscience & Spine Institute to disclose all information and records with respect to myself relating to diagnosis, treatment, prognosis, medical history, physical and mental condition and evaluation thereof to the person(s) listed below. This authorization will remain valid until revoked by me in writing.

Name: ______________________________ ⑨ (Check in box indicates appointment confirmation only)

______________________________ ______________________

Signature of Patient/Responsible Party Date

HEALTH QUESTIONNAIRE

THIS FORM IS TO HELP YOUR DOCTOR PROVIDE YOU BETTER HEALTH CARE.
IT IS COMPLETELY CONFIDENTIAL AND WILL BE A PART OF YOUR MEDICAL RECORD.

Name ______________________ **Age** ________ **Date** ____________

Address ______________________ **Phone** ____________

Please answer all questions. Circle YES or NO. Write in answers where indicated. Thank You.

PAST HISTORY

Did you ever have an operation? YES NO

If yes, list operation and year performed.

____
____
____
____

Did you ever have a serious medical illness, which was not a surgical operation? YES NO

If yes, list illness and year of illness.

____
____
____
____

Have you ever had a serious injury? YES NO

If yes, list injury and date.

____
____
____
____

Are you allergic to any medications? YES NO

If yes, list the medication and your reaction.

____
____
____
____
____

Please list all current medications you are taking.

____
____
____
____
____

FAMILY HISTORY

	LIVING		DECEASED	
	Age	Health	Age	Cause
Father				
Mother				
Brothers				
Sisters				

Have any relatives ever had the following? If so, whom? Yes No

	YES	NO	WHOM
Diabetes			
Heart Trouble			
High Blood Pressure			
Arthritis			
Migraine			
Kidney Disorder			
Goiter			
Cancer			
Tuberculosis			
Stroke			
Epilepsy			
Insanity			

SOCIAL HISTORY- HISTORICAL SOCIAL

What is your occupation?

____

Occupation History ______________________
____
____

Circle if you are: Single Married Widowed Separated Divorced

How many children do you have? ____________

SOCIAL HISTORY CONT.

How much alcohol do you drink? ______________

How much do you smoke? ______________

Hobbies ______________

____

____

Pets ______________

____

____

Do you have frequent or bad headaches? YES NO

Are headaches common in your family? YES NO

Have you ever seen double? YES NO

Has your eyesight blacked out completely? YES NO

Are you bothered by dizzy spells? YES NO

Have you ever had a convulsion? YES NO

Do you have ringing in your ears? YES NO

Are you hard of hearing? YES NO

Do you have nosebleeds? YES NO

Is you nose frequently stopped up? YES NO

Have you had difficulty swallowing or speaking? YES NO

Do you have persistent hoarseness? YES NO

Do you have a feeling of a lump in your throat? YES NO

Do you have hay fever or asthma? YES NO

Do you cough frequently? YES NO

Have you ever coughed up blood? YES NO

Did you ever live with anyone who had tuberculosis? YES NO

Do you have chest pain? YES NO

Does vigorous exertion cause chest discomfort or pressure? YES NO

Are you short of breath? YES NO

Do you become winded walking up one flight of stairs? YES NO

Do you sleep on more than one pillow? YES NO

Have you ever awakened short of breath? YES NO

Does your heart thump or skip? YES NO

Do your ankles swell? YES NO

Have you ever been told you had high blood pressure? YES NO

Have you ever been told you had heart trouble? YES NO

Have you ever had rheumatic fever, growing pains, or heart trouble? YES NO

Have you ever been told you had emphysema? YES NO

Have you lost or gained more than five pounds in the past year? YES NO

Is your appetite poor? YES NO

Do you consider yourself overweight? YES NO

Do you consider yourself underweight? YES NO

Do you suffer from indigestion, heartburn or gas? YES NO

Do you take antacids such as Tums, Rolaids or baking soda? YES NO

Are you often sick to your stomach? YES NO

Do you have frequent vomiting spells? YES NO

Have you ever-vomited blood? YES NO

Have you ever had an ulcer, gallbladder disease, hepatitis, colitis or jaundice? YES NO

Have you ever had severe abdominal pain? YES NO

Have you had any recent change in your bowel movements? YES NO

Do you have loose bowel movements or constipation? YES NO

Do you have hemorrhoids (piles) YES NO

Have you ever had blood in your bowel movements? YES NO

Have you ever had black bowel movements? YES NO

Were you ever treated for "bad blood" (venereal disease)? YES NO

Has a doctor ever said you had a hernia rupture? YES NO

Have you ever passed blood while urinating? YES NO

Do you have trouble starting your stream? YES NO

Do you get up at night to urinate? YES NO

Do you urinate frequently during the daytime? YES NO

Have you had severe burning when you urinate? YES NO

Do you lose control of your bladder? YES NO

Have you ever had a kidney stone or kidney infection? YES NO

Do you have loss of sexual interest? YES NO

Do you have loss of sexual ability? YES NO

Have you ever had arthritis or rheumatism? YES NO

Are your joints ever swollen or painful? YES NO

Have you ever had sugar in your urine or a high blood sugar? YES NO

Do you have diabetes in your family? YES NO

Do you feel thirsty? YES NO

Have you ever had boils or other skin infections? YES NO

Do you become weak if you do not eat? YES NO

If yes, will it occur between ordinarily paced meals? YES NO

Do you frequently have weak, shaky spells, which are relieved by eating? YES NO

If yes, will this occur only if a regular meal is missed? YES NO

Have you ever taken thyroid hormones? YES NO

Have you ever had a goiter (thyroid enlargement)? YES NO

Do you have bleeding gums? YES NO

Do you bruise easily? YES NO

Have you ever been anemic? YES NO

Have you ever had a blood transfusion? YES NO

Do you have lumps in your neck, under your arms, or in your groin? YES NO

Are you considered a sickly person? YES NO

Do you have difficulty falling asleep or staying asleep? YES NO

Do you awaken tired in the morning? YES NO

Do you often have spells of complete exhaustion? YES NO

Does work tire you out completely? YES NO

Do you push or drive yourself most of the time? YES NO

Does worrying get you down? YES NO

Are you considered a nervous person? YES NO

Did you ever have nervous breakdown? YES NO

Did anyone in your family ever have a nervous breakdown? YES NO

Are your feelings easily hurt? YES NO

Do people misunderstand you? YES NO

Are you easily upset or irritated? YES NO

Do you often get into a violent rage? YES NO

Do you often shake or tremble? YES NO

Are you constantly keyed up or jittery? YES NO

Do frightening thoughts keep coming back in your mind? YES NO

Do you often cry? YES NO

Do you feel unhappy and depressed? YES NO

Are you always miserable and blue? YES NO

Does life look entirely hopeless? YES NO

Do you often wish you were dead and away form it all? YES NO

Please list dates you have had the following...

Rectal Exam ______________________________

____

Pelvic Exam ______________________________

____

Pap Smear ______________________________

____

Mammogram ______________________________

____

Cardiac Lipid Profile ______________________________

____

Immunizations ______________________________

____

____

THIS SECTION FOR WOMEN PATIENTS ONLY

Are your menses irregular? YES NO

Do you have severe cramps with your menses? YES NO

Do you have hot flashes? YES NO

Are you bothered by an irritating vaginal discharge? YES NO

Do you have discharge from your breasts? YES NO

Have you ever been pregnant? YES NO

Have any of your babies weighed 8 lbs. or more at birth? YES NO