Patient Information

Today's Date ____________________
Date of Birth ____________________

Patient Name ______________________________ Social Security # ____________________
Home Address ____
City ______________________ State __________ Zip Code __________
Work Address ____
City ______________________ State __________ Zip Code __________
Home Phone ______________________ Work Phone ______________________
Cell Phone ______________________

In case of Emergency Please Notify:

Name ______________________
Address ____
Phone ______________________

The following information is required by the state of Nevada.
Are you hispanic? yes no If yes, what nationality (ie. Cuban, Mexican etc.)? ____________________
Race: ☐ Native American ☐ Black ☐ White ☐ Other (specify) ____________________
Please indicate the highest school grade you completed (0-12)________ College? ☐ yes ☐ no ______ years

Federal privacy rules require that you tell us how to contact you with information, lab results, appointment changes, and other information that is crucial to your care with Birth Control Care Center.

Please check all that apply.

The best way to telephone me is:

- ☐ Call my home number
- ☐ Call my work number
- ☐ Call my cell number
- ☐ Never call me

If you have to leave a message, say...

- ☐ "Birth Control Care Center called"
- ☐ "your doctor's office called"
- ☐ "Casey called" (this is our 'code' for a call from this clinic)

☐ Please list any other way to reach you ______________________________________

I understand that staff may periodically need to contact me about test results or other information about my care with Birth Control Care Center. I have made my preferences known about how to contact me.

I also understand that critical situations may arise that require Birth Control Care Center to make contact with me quickly. If unable to do so, I understand that Birth Control Care Center may send certified mail to my home address as a way to make direct contact with me. By signing below I agree to BirthControl Care Center's contact procedures.

______________________________ ______________________________
Patient Signature Witness

______________________________ ______________________________
Parent or Guardian Date and Time

How did you hear about Birth Control Care Center?

- ☐ Yellow Pages
- ☐ Internet
- ☐ Referred by Dr. ______________
- ☐ Referred by Planned Parenthood
- ☐ Referred by a friend
- ☐ Saw ad in ______________
- ☐ Radio Ad
- ☐ Been here before
- ☐ Other ______________

Patient Privacy Notice

In accordance with the Federal Privacy Law (HIPPA), Birth Control Care Center keeps medical information and records confidential and will only use them for patient treatment, health care operations, and billing pruposes.

Treatment:
Our physicians, clinicians, and staff will use your medical information to give you the best possible care.

Health Care Operation:
Birth Control Care Center will use this information for appropriate follow-up care, patient notification, statistical and regulatory requirements, and internal quality assurance programs.

Billing Purposes:
Birth Control Care Center will use your medical information to bill the appropriate third party or parties for your care.

Disclosure of Information with Extenuating Circumstances

1. Health information will be given to family members in case of an emergency or under other circumstances with proper authorization and documentation.
2. Health information may be given to other physicians or institutions under emergency situations.
3. Information may be given to proper authorities when neglect or abuse is alleged or suspected.
4. Information may be provided to courts or other agencies when a subpoena is given to this office.

I understand that if I have any questions I can speak to a Birth Control Care Center Privacy Officer.

I understand and agree to the above Privacy Policy.

______________________________	______________________________
Patient Signature	Witness
______________________________	______________________________
Patient name - Printed	Date and Time

I agree to allow Birth Control Care Center to contact my referring physician for the purpose of continuity of care.

Yes ______ No ______ N/A ______ Initials ________

Medical History

Patient Name ______________________ Age __________ Date ______________

How many times have you been pregnant, including this time? ________

Please indicate below how your previous pregnancies ended.

# of live births ________ # of miscarriages ________ # of abortions ________ # of c-sections ________

Have you ever had an ectopic or tubal pregnancy? ☐ Yes ☐ No

Have you ever had complications after childbirth, abortion, or miscarriage, including excessive bleeding?
☐ Yes ☐ No explain ______________________

When did your last menstrual period start? ____________ Was it a normal period? ☐ Yes ☐ No

Have you had any bleeding since your last period? ☐ Yes ☐ No

What birth control methods have you tried? ______________________

Please list any operations that you have had including c-sections, D&C's, and procedures on your cervix:

____

Have you ever had an operation to burn or freeze the lining of your uterus to stop your periods? ☐ Yes ☐ No

Are you allergic to any medications? ☐Yes ☐ No If yes, please list the medications and type of reaction below:

____

Are you allergic to latex? ☐ Yes ☐ No

Are you currently on any medications? ☐ Yes ☐ No If yes, please list them below:

____

Do you use any recreational drugs such as cocaine, heroin, methamphetamine, etc.? ☐ Yes ☐ No

If yes, which drug(s)? ______________________ When did you last use? ______________

Do you smoke? ☐ Yes ☐ No Are you currently breastfeeding? ☐ Yes ☐ No

Please check if you have, or have had any of the following?

- ☐ Reaction to iodine
- ☐ Reaction to novacaine or other anesthetics
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding tendencies
- ☐ Blood transfusions
- ☐ Blood clots in your legs or lungs
- ☐ Breast lumps or tumors
- ☐ Diabetes
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Kidney disease
- ☐ Migraine headaches
- ☐ Mitral valve prolapse
- ☐ Psychiatric illness
- ☐ Seizures or epilepsy
- ☐ Pelvic inflammatory disease (PID)
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Genital warts
- ☐ Herpes
- ☐ Syphilis
- ☐ Other ______________

I certify that the information I have provided is true, correct, and complete.

Patient signature ______________________ Date ____________

ROS ______________________

☐ History reviewed with patient

Physician signature ______________________ Date ____________