Abraham Duel, M.D., Inc.
OBSTETRICS & GYNECOLOGY

ABRAHAM DUEL, M.D.
301 North Main Street
Santa Ana, CA 92701

PATIENT INFORMATION

Patient's Last Name .....First Name.....MI .....
Patient's Address .....
City.....State.....Zip-Code .....Sex (M/F) .....
Home Phone (.....) .....Work Phone (.....).....
Date of Birth .....Social Sec # .....
Driver Lic #.....Referred By.....
Is Patient a Minor (Y/N) ? .....If Yes Guarantor Name .....
Guarantor Address.....
City.....State .....Zip Code.....
Guarantor Phone # (.....).....Date of Birth.....Phone # (.....).....
Social Sec # .....Driver Lic # .....
Employer Name.....Occupation.....
Employer Address.....
City.....State .....Zip Code.....
Name of Nearest Relative not living with you.....
Address.....
City.....State .....Zip Code.....
Relation to Patient .....Phone # .....

INSURANCE INFORMATION

Primary Insurance Co Name.....Phone # (.....).....
Address.....Phone # (.....).....
City.....State .....Zip Code.....
Insurance ID #.....Group #.....Plan # .....
Insured's Party Last Name .....First Name.....MI .....
Secondary Insurance Co Name.....Phone # (.....).....
Address.....Phone # (.....).....
City.....State .....Zip Code.....
Insurance ID #.....Group #.....Plan # .....
Insured's Party Last Name .....First Name.....MI .....

ASSIGNMENT: I hereby assign my insurance to be paid directly to the undersigned physician.
I am finacially responsible for non-covered services.

Signed : (Patient or Guarantor, if minor) .....Date ...../...../.....

For office use only Dr # ..... Dr Name.....[ ] Cash [ ] Insurance

AMCO

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OBSTETRICS & GYNECOLOGY

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Santa Ana, CA 92701

Referred By _____

HEALTH QUESTIONNAIRE

Date _____

Dear Patient: The purpose of this form is to help you remember everything that should be checked. Please fill it out completely.

PLEASE PRINT

Name _____ Address _____
LAST FIRST MIDDLE STREET CITY STATE ZIP

Age _____ Occupation _____ Religion _____

Underline: Single, Married (_____years), Widow, Divorced, Separated, Remarried

Underline the main reason you came to see the doctor:
Pain Irregular Bleeding Possible Pregnancy Discharge Urinary Symptoms For Cancer Test Family Planning Infertility
Protruded Organs Other condition: _____

Menstruation: Started at age _____ Number of days from start of one to start of next period _____

Number of days period lasts _____ Date of last normal menstrual period (1st day) _____

Obstetric History: How often have you been pregnant? _____ How many full term babies? _____

Prematures? _____ Miscarriages? _____ Stillborns? _____ Ages of children _____

Please circle Yes or No after the following questions

Are your periods irregular?	yes	no	Is your diet poor?	yes	no
Are they painful?	yes	no	Do you vomit?	yes	no
Do you pass clots with them?	yes	no	Do you often eat between meals?	yes	no
Do you bleed between periods?	yes	no	Do you drink more than two drinks/day?	yes	no
After douching or marital relations?	yes	no	More than six cups of coffee?	yes	no
Do you get tense before periods?	yes	no	Smoke more than a pack a day?	yes	no
Do you have any symptoms of pregnancy?	yes	no	Do you take any medicine?	yes	no
Is it hard for you to get pregnant?	yes	no	Birth control pills?	yes	no
Are relations uncomfortable?	yes	no	Other _____	yes	no
Are you troubled with a discharge (other than blood)?	yes	no	Do your ankles swell?	yes	no
Does it itch or irritate?	yes	no	Do you have varicose veins?	yes	no
Ever had any other female trouble?	yes	no	Do you get short of breath?	yes	no
Do you urinate too often?	yes	no	Do you faint easily?	yes	no
Do you get up at night to urinate?	yes	no	Do you get headaches?	yes	no
Do you have to go "right now?"	yes	no	Do you get hot flashes?	yes	no
Do you pass blood in the urine?	yes	no	Do you sleep poorly?	yes	no
Do you lose urine when you cough or laugh?	yes	no	Do you wake up tired?	yes	no
Does it feel like anything is pushing out of your vagina?	yes	no	Do you cry easily?	yes	no
Do you have to push anything up to empty the bowels or bladder?	yes	no	Have you ever been treated for nerves?	yes	no
Are you constipated?	yes	no	Are you dissatisfied with your work?	yes	no
Do you often have diarrhea?	yes	no	With your family situation?	yes	no
Ever pass blood in the stools?	yes	no	Have you ever been operated upon?	yes	no
Ever have black stools?	yes	no	(list operations & dates)		
Have painful bowel movements?	yes	no	_____		
Have you gained or lost weight?	yes	no	_____		
Is your appetite poor?	yes	no	Have you had any serious injuries?	yes	no
			Any blood transfusions?	yes	no
			Have you ever been hospitalized for anything else?	yes	no

Circle any of these you have had:

Arthritis	Birth Defect	Heart Trouble	Jaundice (Hepatitis)
Allergies	Convulsions	High Blood Pressure	Lung Trouble
Anemia	Diabetes	Kidney Trouble	TB
			VD - G.C., Syphilis, Herpes

Circle any of the following occuring in your family:

Arthritis	Cancer	High Blood Pressure	Strokes	Twins
Birth Defects	Diabetes	Mental Illness	TB	

After you complete this form, the Nurse will weigh you, check your blood pressure, and test your blood and urine. She will then take you into the Doctor's office. Please feel free to tell him your history in your own words. Thank you.

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Copy: You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our Contact Person. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Helda Duel, Privacy Officer
301 N. Main St.
Santa Ana, CA 92701
714-547-6641

Effective Date: April 13, 2003

I_____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____Date:_____

If not signed, reason why acknowledgement was not obtained:_____

Staff Witness seeking acknowledgement

_____Date:_____