

Kate O'Hanlan MD
Gynecologic Oncology Associates
4370 Alpine Road, Suite 104
Portola Valley, CA 94028-7927
Telephone: (650) 851-6669
Fax: (650) 851-9747

Name: _____
Date: _____ Age: _____
Primary Doctor: _____

New Patient History

Medical Allergies: _____ Effect _____ No Allergies
Reason for Visit: State onset, duration, location, severity, associated symptoms

Health Habits Height _____ Weight _____

Exercise: Walk some Exercise some Exercise >30 min. 3x/week
Multi-vits: None Sometimes Always Calcium
Daily Aspirin: None Sometimes Always
Low Fat Diet: None Sometimes Usually Rigorous, 5+ fruits/vegetables daily
Safer Sex: Not Needed Need Information

Habits: Alcohol: Never Quit Recovering Current Use# _____/Week Type _____
Drugs: Never Quit Recovering Current Use# _____/Week Type _____
Tobacco: Never Quit Recovering Current Use# _____/Week Type _____

Family History	List Relation	Age at Diagnosis	Status
Breast Cancer	_____	_____	_____
Colon Cancer	_____	_____	_____
Ovary Cancer	_____	_____	_____
Heart Disease or Stroke	_____	_____	_____
Osteoporosis	_____	_____	_____

System Review

Skin	<input type="checkbox"/> Negative	<input type="checkbox"/> Rash	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Excess Hair
Neurological	<input type="checkbox"/> Negative	<input type="checkbox"/> Fainting	<input type="checkbox"/> Seizures	<input type="checkbox"/> Headaches	<input type="checkbox"/> Other _____
Psychiatric	<input type="checkbox"/> Negative	<input type="checkbox"/> Depression	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Rape/Molestation	<input type="checkbox"/> Other _____
Endocrine	<input type="checkbox"/> Negative	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Other _____
Urological	<input type="checkbox"/> Negative	<input type="checkbox"/> Bloody Urine	<input type="checkbox"/> Painful Urine	<input type="checkbox"/> Leakage	<input type="checkbox"/> Infection
Hematol/Lymph	<input type="checkbox"/> Negative	<input type="checkbox"/> Bruises Easily	<input type="checkbox"/> Bleed Easily	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Anemia
Allergy/Immunol	<input type="checkbox"/> Negative	<input type="checkbox"/> Fever	<input type="checkbox"/> HIV	<input type="checkbox"/> Other _____	
Weight	<input type="checkbox"/> Stable	<input type="checkbox"/> Wt. Gain	<input type="checkbox"/> Wt. Loss		
Eyes	<input type="checkbox"/> Negative	<input type="checkbox"/> Change in Vision	<input type="checkbox"/> Injury	<input type="checkbox"/> Other _____	
ENT/Mouth	<input type="checkbox"/> Negative	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Infection	<input type="checkbox"/> Other _____	
Cardiovascular	<input type="checkbox"/> Negative	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Irreg-Rhythm	<input type="checkbox"/> Murmur _____	<input type="checkbox"/> High BP
Respiratory	<input type="checkbox"/> Negative	<input type="checkbox"/> Short of Breath	<input type="checkbox"/> Asthma	<input type="checkbox"/> Other _____	
GI	<input type="checkbox"/> Negative	<input type="checkbox"/> Nausea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Bloody Stool
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other _____			
Musculoskeletal	<input type="checkbox"/> Negative	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Other _____		
GYN/Sexual Function	<input type="checkbox"/> Normal	<input type="checkbox"/> Problem	<input type="checkbox"/> Vaginal Disch.	<input type="checkbox"/> Abn Bleeding	<input type="checkbox"/> Painful Sex
	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Abn Pap Smear	<input type="checkbox"/> Herpes	<input type="checkbox"/> Warts	<input type="checkbox"/> Pelvic Pain
	<input type="checkbox"/> DES Exposure	<input type="checkbox"/> Few Orgasms	<input type="checkbox"/> Libido Low	<input type="checkbox"/> Dry vagina	

Reviewed by _____

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Name: _____

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Primary Doctor: _____

Past Surgical History (List All Surgeries, Year Performed)

Past Medical History (List all Illnesses, Hospitalizations, Year Diagnosis)

Current Medications (Include Hormones, Supplements) **No Medications**

Rx _____	Dosing _____	Rx _____	Dosing _____
Rx _____	Dosing _____	Rx _____	Dosing _____
Rx _____	Dosing _____	Rx _____	Dosing _____
Rx _____	Dosing _____	Rx _____	Dosing _____

Past Screening History (List Month, Year, Results)

Cholesterol	____/____	Results: _____	Due _____
Pap Smear	____/____	Results: _____	_____
Mammogram	____/____	Results: _____	_____
Colonoscopy	____/____	Results: _____	_____
Bone Density	____/____	Results: _____	_____
Cardiac Testing	____/____	Results: _____	_____
Regular Dental	____/____	Results: _____	_____

Obstetric/Gynecological History

Menses: Age at Onset: _____
 Regular: Yes No
 First Day of Last Period: _____
 Cycle Intervals: _____ days (start to start)
 Days of Flow: _____ days
 Flow: Light Mod Heavy
 Pain: None Mild Mod Severe
 PMS: None Mild Mod Severe

List Pregnancies (include Miscarriages / Abortions) None

Year	Sex	Wt.	(Vag/CS)	Anesth	Complications

Contraception Method: _____
 Duration of Use: _____ None

Prior Treatment of abnormal Pap Smear: Never Yes (when?) _____

Received HPV Vaccine: No Yes (when?) _____

Menopause: No Yes Age at menopause: _____ No Spotting Yes: Spotting, Staining, Bleeding

Hormone Replacement: Estrogen: _____ Dosage _____ Duration Use: _____
 Progesterin: _____ Dosage _____ Duration Use: _____

Reason for HRT: Hot Flashes Insomnia Dry Vagina Not Sure Other: _____

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Gynecologic Oncology
A s s o c i a t e s

Patient (Please Print Clearly)

Name: _____
Address: _____
City/State/Zip: _____
Birth Date: _____ Sex: M F FTM MTF I
Home Phone: _____ Cell: _____
Employer: _____
Employer Telephone No.: _____
Emergency Contact Person: _____
Emergency Contact Phone: _____
Social Security Number: _____

Status: Married Single Divorced Widow Domestic Partner

Referring Doctor (if applicable):		

FIRST	LAST	

ADDRESS	Signature of Person Signing Form	

CITY	STATE	ZIP CODE

PHONE NUMBER	FAX NUMBER	

UPIN# _____	STATE LIC# _____	
(Office Use Only)	(Office Use Only)	

Subscriber

Name: _____
Address: _____
City/State/Zip: _____
Birth Date: _____ Sex: M F FTM MTF I
Telephone Number; _____
Social Security Number: _____
Medicare No.: _____
Insured's I.D. No.: _____
Group No.: _____
Effective Date of Insurance Coverage: _____
Insurance Company Name: _____
Insurance Address: _____
City/State/Zip: _____

Your Local Pharmacy and Phone Number: _____

Please Read and Sign the Following Consents:

- I, the undersigned, have insurance coverage with _____ Insurance Company, and assign directly to Dr. Kate O'Hanlan all surgical and / or medical benefits, if any, otherwise payable to me for services rendered, I hereby authorize the doctor to release all information necessary to secure payment or benefits.
Date: _____ Signature: _____
- We often get inquiries from family members and friends about the status of our patients. Please indicate what your wishes are regarding release of your medical information.
 You may release information to any interested party.
 You may release information only to the following persons: _____
 Please do not release information to anyone other than myself.
Date: _____ Signature: _____
- I understand that during the course of my treatment, I may be tested for antibodies to the HIV Virus (Aids Virus).
Date: _____ Signature: _____
- I acknowledge that the medical group engages in clinical research and that the physicians and employees of the medical group may have a financial interest in companies with whom they conduct research or do business. I understand that such financial interests shall in no way modify or compromise my care.
Date: _____ Signature: _____

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Financial Policy

Please review the following financial policy. We would be happy to answer any questions regarding your insurance or payment issues.

Please review the next page for a partial list of insurance plans with which Dr. O'Hanlan is currently contracted. This list is subject to change and we advise you to ALWAYS let us know your insurance in case our contracts have changed with your insurance carrier.

All co-payments are due at the time of check-in for your appointment.. Payment is accepted by check, exact cash, Visa/MC. All non-contacted services are due at the time services are rendered. We will be happy to bill your non-contracted insurance company as a courtesy. We do not courtesy bill HMO's or International carriers.

If you are having surgery, we will contact your insurance company regarding your benefits and coverage. We will discuss our fees, your portion of the financial responsibility and any other questions that arise. If we are contracted with your insurance carrier, we will let you know the amount of the deposit required prior to your surgery date. If we are not contracted with your insurance carrier, you will be asked to make the full payment for Dr. O'Hanlan's fee on the day of your preop appointment.

Please remember our relationship is with you and not your insurance company. All charges are your responsibility. Your insurance carrier will only pay for services that it determines to be "reasonable and necessary" which may not be in keeping with necessities of your health care.

We accept cash and checks from patients not using their insurance who are paying surgical fees in full. We accept cash, checks, Visa and MasterCard from patients utilizing insurance coverage. Returned checks are subject to a \$20.00 service charge.

Our billing agency is the central office of Gynecologic Oncology Associates, our group of 23 California Gynecologic Oncologists. You can call them with billing questions at (800) 416-0888.

I have read and understand the above financial policy.

I authorize my insurance benefits to be paid directly to my physician and am financially responsible for non-covered services.

Patient Pignature _____ Date _____

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Partial List of Insurance Companies

with whom we currently participate:

Admar Corp (Med Network PPO)
Aetna PPO
American Benefit Plan Administrators
Blue Cross of CA (Prudent Buyer) PPO
Blue Cross HMO (ONLY if PCP is a direct contractor –
not part of a group-and only with a written referral)
BPS
Capp Care
CCN PPO
Champus (Tricare)
Cigna PPO
DirectCare America
First Health PPO
Health Net (direct network only)
Interplan PPO
Medicare
MediCal (PENDING)
Great West (formerly One Health Plan) PPO
Pacific Health Alliance PPO, EPO
PHCS
Physicians Foundation for Medical Care-Santa Clara County
Preferred Health Network
Prudential Healthcare PPO
Universal Care PPO
USA Managed Care Org, PPO