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

Reviewed by _____

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Name: _____

Date: _____ Age: _____

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) Due

Cholesterol _____/____ Results: _____ _____
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: _____
Progestin: _____ Dosage _____ Duration Use: _____
Reason for HRT: ❍ Hot Flashes ❍ Insomnia ❍ Dry Vagina ❍ Not Sure ❍ Other: _____

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GynecologicOncology
Associates

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:

1. 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: _____

2. 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: _____

3. I understand that during the course of my treatment, I may be tested for antibodies to the HIV Virus (Aids Virus).

   Date: _____ Signature: _____

4. 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