Sudha Moola MD
M.D., F.A.C.O.G.
818 Magnolia Ave STE 102
Corona, CA 92879

call : (951) 732 – 7834
fax : (951) 352 - 7758

Please complete the following information. **This information is confidential**

Name:_____
Last Mi First

Address:_____ City:_____State:____

Zip:_____--_____E-mail address:_____

Home phone:_____ Work/cell phone:_____

By providing a phone number, mobile phone number or email address, I authorize Dr. Sudha Moola to contact me or my guardian/legal representative by email, voice or text to remind me of appointments, to obtain feedback on my experience at this office, and to provide general health reminders and other information regarding my healthcare. ☐ Yes ☐ No

Birth Date: _____ Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Marital Status: ☐ Single ☐ In a relationship ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race/Ethnicity: ☐ Asian ☐ African American ☐ Hispanic or Latino ☐ Caucasian ☐ Other _____

In case of emergency, contact:

Name:_____Relationship:_____ Phone:_____
Last Mi First

Please list: Special needs: _____ Allergies:_____

Referred By _____

Responsible Party Information: (Must provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.)

Responsible party: Another patient ☐ Guarantor ☐ Self ☐ Information is same as patient ☐

Insurance company: _____ID #_____Co-Pay _____

Policy holder's name: _____ Policy holder's date of birth: _____

Policy holder's relationship to patient: _____ Phone: _____

Policy holder's address: _____

City:_____State:_____ZiP:_____--_____

Preferred Pharmacy:_____ Phone _____

STUDENTS AND MINORS:

Parent/Legal Guardian _____ Date of Birth _____

Address _____ Phone _____

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

Thank you for choosing Dr. Sudha Moola as your health care provider. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following Financial Policy.

To properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any changes of insurance information. **It is the insurance company that makes the final determination of your eligibility and benefits.**

I understand Dr. Sudha Moola:

- Expects Non-Insured or Insured patients to pay co-pays, deductibles on the date of service or make payment arrangements.
- Outside lab tests are billed separately by that company. However, some of these may not be covered by my insurance plan and these will be my responsibility to pay in advance.
- Expects my insurance company to pay within 90 days from the date of service if not paid bill me directly.
- Expects the parent or guardian to pay for all services rendered to their dependents.
- Expects me to keep appointments and to call at least 24 hours prior, if I need to cancel.
- I understand that failure to keep my appointments may result in being discharged from the practice.
- High-Deductible health plan requires me to pay half of service charges at the time of service. The remaining balance will be due upon receipt of a statement from doctor's office.
- I hereby authorize payment of all insurance, Medicaid and/or Medicare benefits directly to Dr. Sudha Moola and I authorize them to file insurance on my behalf. I also authorize them to release medical and/or account information to satisfy claims

I have read and understand the above:

_____ _____

Patient or Parent/Legal Guardian Signature Date

Note: Failure to sign does not relieve you of the above expectations

CONSENT FOR TREATMENT

I voluntarily consent to routine services, medical treatment(s), diagnostic radiology procedure(s), diagnostic lab(s), behavioral health services and services offered by lay health workers (i.e. doula, community health worker, peer support specialist) as deemed necessary by the healthcare providers treating me. I voluntarily consent to allow **Dr. Sudha Moola** to seek emergency medical care from a physician or hospital, if needed. I understand that diagnostic procedures may include but are not limited to lab tests on blood, urine, and tissue, including drug screenings and HIV. I understand that diagnostic radiology procedures include but are not limited to x-ray, ultrasound and/or mammography. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand I have the right to ask questions about my treatment and/or procedures and the right to refuse any treatment or procedure. I agree to notify my provider of my concerns.

NOTICE OF PRIVACY AND PATIENT HIPAA CONSENT

I have been given the opportunity to read **Dr. Sudha Moola's** Notice of Privacy Practices, and my questions concerning the Notice have been answered. I understand if I choose not to sign this acknowledgment **Dr. Sudha Moola** will continue to provide services to me and will use and disclose my Protected Health Information (PHI) for treatment, payment, and healthcare operations when necessary.

_____ _____

Patient or Parent/Legal Guardian Signature Date

VERBAL COMMUNICATION CONSENT

Dr. Sudha Moola is authorized to discuss medical and financial information with the following individuals:

_____ _____ _____

Name Phone Number Relationship to patient

CONFIDENTIAL PERSONAL HEALTH HISTORY

Patient Name:_____ Height:_____ Weight:_____

1. Last pap smear? Date:_____ Place:_____
2. Was it □. Normal or □ Abnormal
3. Last Mammogram: Date:_____

Menstrual History:

4. Last menstrual period occurred on:_____
5. Age of first Mensuration?_____ Cycle Days:_____ Duration:_____
6. Do you have cramps? □. Yes or □ No. If so □. Miled or □ Moderate or □. Severe
7. Do you have bleed or spot between periods? □. Yes or □ No.
8. Do you bleed or spot after intercourse? □. Yes or □ No.
9. Have you ever been a victim of sexual abuse , domestic violence or rape? □. Yes or □ No.

Gynecology History

STD. □	Ovarian CYST □	HIV □	Herpes □
Vaginal Warts □	Headache/Migraine □	Endometrioses. □	Infertility □
Urinary Leakage □	Fibroids □	Pelvic Infection. □	Transfusion. □

Previous Pregnancies: Please give all the information in regard to your previous pregnancies

Year of Birth	Birth weight of Infant	Birth Height of Infant	Hours of Labor	Type of Delivery	Complications

Past Medical History

Asthma □	Tuberculosis □	Diabetes □	Hypertension □	Heart Disease □
Mitral Valve prolapse□	Kidney disease □	Gallbladder disease □	Neural disorder □	Chicken pox □
GI Abnormality □	Thyroid Disease □	Blood Clots □	Cancer □	Drug Sensitivity □
Varicosities □	Thrombophlebitis □	Accidents □	Syphilis □	Pneumonia □
Epilepsy □	Jaundice □	Hepatitis □	STD □	Anemia □

Past Surgical History

Surgery/Transfusion/Hospitalization/Anesthetic Complications	Date	Notes

Signed:_____ Dated_____

Patient Name:_____ **DOB:**_____

Current Medication List

Pharmacy Name:	
Pharmacy Location:	
Known medication allergies:	
Family Physician name:	
Medications you take:	

Habits:

10. Do you smoke? □. Yes or □ No. Packs per Day:_____
11. Do you drink Alcohol? □. Yes or □ No. Drinks per Day:_____
12. Do take Caffeine? □. Yes or □ No. Drinks per Day:_____
13. Do you take drugs(Recreational)? □. Yes or □ No.

Family History:

Past Surgical History

	Illness/Death	Age	Cause
Father			
Mother			
Paternal(Grand Father)			
Paternal(Grand Mother)			
Maternal (Grand Father)			
Maternal (Grand Mother)			

Reason for Visit:

14. PAP □
15. STD Screening □
16. Pelvic pain □
17. Vaginal Discharge □
18. Abnormal Vaginal Bleeding. □

19. Others:_____

20. Notes:_____

Signed:_____ **Dated**_____