SAN DIEGO CENTER for GYN ONCOLOGY

Thank you for choosing San Diego Center for GYN Oncology for your care. This packet contains information you will need for your appointment. Please review this information closely and contact our office prior to your appointment if you have any questions.

Kris Ghosh, M.D M.B.A. Sue Ghosh, M.D.

Our address is: 25495 Medical Center Dr
Suite 303
Murrieta Ca 92562

Fax or mail records to: San Diego Center for GYN Oncology
955 Boardwalk St. Suite 100
San Marcos Ca 92078
Fax: 760 471-0211

If you need to change or cancel you appointment please contact us at 760-471-0200. We ask that you give us 24 hours advance notice. Directions to our office are on the following page.

Please plan to have your medical records forwarded to our office prior to your appointment. Contact your referring physician for their policy on how to forward your medical records. Failure to have medical records prior to your appointment could result in the appointment being cancelled or rescheduled. We have enclosed a medical release for your convenience.

It is important that you bring your health insurance card and picture identification with you to your appointment. It is your responsibility to check with your insurance company to assure coverage of these services. You are responsible for charges not covered by your insurance.

Please review and complete all of the attached information and return it to our office within **2 days** prior to your appointment. We have found this information to be helpful when we discuss and plan your health care and treatment with you.

Thank you,
San Diego Center for GYN Oncology

San Diego Center for GYN Oncology

Dr. Kris Ghosh and Dr. Sue Ghosh

Our address is:
25495 Medical Center Dr.
Suite 303
Murrieta Ca 92562

Please be sure to contact out office at 760-471-0200 prior to your appointment if you have any questions about directions.

Finding your way to

San Diego Center for GYN Oncology
25495 Medical Center Dr. suite 303 Murrieta Ca 92562

From the 15 North:
15 south exit Murrieta hot springs rd
Take the Murrieta hot springs exit
Turn left on to Murrieta hot springs road
Take the first left on Hancock Ave
Take the first right on to Medical Center Dr
Our office is located at the end to the right Tower Plaza II
(Same building as Urology and Temecula Day Surgery Center)

From the 215 North:
215 north exit Murrieta hot springs road
Turn right and go over pass
Turn right on Hancock
Turn right into Medical Center Dr.
Our office is located at the end to the right Tower Plaza II
(Same building as Urology and Temecula Day Surgery Center)

From the 15 South:
15 south get on the 215 North
Take the Murrieta hot springs road exit
Turn left on to Murrieta hot springs road
Turn right on Hancock
Turn right on Medical Center Dr
Our office is located at the end to the right Tower Plaza II
(Same building as Urology and Temecula Day Surgery Center)

SAN DIEGO CENTER for GYN ONCOLOGY

San Diego Center for GYN Oncology
955 Boardwalk St suite 100
San Marcos Ca 92078
Phone: 760-471-0200
Fax: 760-471-0211

Patient Name:_____
Date of Birth:_____
Address:_____
Home telephone #:_____ Cell Phone #:_____
I hereby authorize:_____
Address:_____
Phone #:_____Fax:_____
To release my medical information to: San Diego Center for GYN Oncology
955 Boardwalk St #100
San Marcos CA 92078
760-471-0200-Phone
760-471-0211-Fax

Purpose of disclosure:_____ Dates of Service;_____

Type(s) of Medical information to be disclosed ("X" all appropriate boxes):

□ History and Physical
□ EKG(s)
□ Lab Report(s)
□ Complete medical record
□ Discharge Summary
□ Operative Reports
□ Pathology Reports
□ Endoscopy Report(s)
□ Radiology Report(s)
□ Other (specify)_____

I understand and acknowledge that this Authorization extends to all or part of the records designated above. A separate authorization is required for the release of psychotherapy notes or the release of medical information for research purpose. I understand that I may revoke this Authorization at any time after I have signed it by providing San Diego Center for GYN Oncology with a written statement that I wish to revoke this Authorization. My revocation of Authorization will be effective immediately and my medical information can no longer be disclosed pursuant to this Authorization except to the extent that disclosure have already been made in reliance upon this Authorization.

This Authorization is valid for one year, unless an earlier date or condition/event is specified here _____ or unless revoked by me in writing before the release of the above designated information.

_____ _____
Signature of patient Date

- If this Authorization is signed by a legal representative of the patient (for example, the parent or legal guardian if the patient is a minor) a description of such representative's authority to act for the patient must also be provided (check applicable box and/or explain your authority to sign for the patient below) except for legal representatives acting in the capacity as a parent to the patient, also attach a copy of documentation giving you authority to sign this Authorization on behalf of the patient

____ Parent ____ Guardian
___ _Power of Attorney ____Administrator/Executor of Estate

SAN DIEGO CENTER for GYN ONCOLOGY

Acknowledgement of Fees

Lab Service Fees: You will receive a statement from the laboratory for all services. These facilities may not be a contracting provider with every insurance company. **Initial:** _____

Insurance Billing: As a courtesy to our patients we will bill your insurance carriers. We also bill secondary insurances. It is the responsibility of our patients to notify us of any changes to their insurance. **Initial:** _____

Financial Policy: Payment for professional fees is due in full at the time service is provided in our office. Co-payments, coinsurance and non-covered services are also due at the time of your visit. If we are unable to verify your insurance eligibility/benefits prior to the time of your appointment, you are required to pay in full at the time services are rendered. If your deductible has not been met you will be required to pay for your office visit in full until your deductible has been met in full. **Initials:** _____

Surgery Fees: All co-pays, deductibles, and payment for non-covered surgical procedures are due prior to your surgery. **Initials:** _____

Failed Appointment: If you are unable to keep your appointment, please call the office to cancel or reschedule at least 24 hours prior to avoid our $35.00 failed appointment fee.
Initial: _____

Assignment of Insurance Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled, private insurance and other health plans to: San Diego Center for Gyn Oncology while under the care of Dr. Kris Ghosh and Dr. Sue Ghosh. **Initials:** _____

Acknowledgement of Receipt of Notice of Privacy Practices: I hereby acknowledge I have been offered a copy of San Diego Center for GYN Oncology Notice of Privacy Practices. I further acknowledge that a copy of the privacy practices and any amended copies will be available at the reception desk upon request. **Initials:** _____

Disability/Insurance/Family Medical Leave Act (FMLA) Forms: Payment for professional fees are due in full before completion of form. There will be a $25.00 fee for each disability form, a $25.00 fee for each insurance form, and a $35.00 fee for each FMLA form. **Initials:**_____

Notice to Consumers: Medical Doctors are licensed and regulated by the Medical Board of California, (800) 633-2322 www.mbc.ca.gov. **Initials:** _____

Patient Signature Date

SAN DIEGO CENTER for GYN ONCOLOGY

Patient Registration

Patient Name_____ Social Security #_____
Last First MI
Birthdate:__/___/___ Age:_____ Race:_____ Marital Status:_____

Address:_____
Street City State Zip
Home Phone:_____ Cell:_____ Alt;_____
May we leave a message at the above phone number (with other residents/answering machine/voice mail)? ( ) Nes ( ) No

Patient Employer:_____ Employer Phone:_____

Employer Address:_____
Street City State Zip
Emergency Contact:_____ Phone:_____ Cell:_____

Relationship_____ Address:_____
Street City State Zip
Spouse, Parent, or Guardian_____ SSN #_____ Birthdate ___/___/__

Employer:_____ Employer Phone:_____

Employer Address:_____
Street City State Zip
Responsible Party for Insurance and Bills: ( ) Self ( ) Spouse ( ) Parent ( ) Other _____

Insurance Company:_____ Subscriber Name:_____
Relationship to card holder: ( ) Self ( ) Spouse ( ) Dependent

ID #_____ Group #_____ Provider Phone #;_____

Insured: I hereby authorize San Diego Center for GYN Oncology to furnish my designated insurance company all information acquired in the course of my examination or treatment. I also authorize benefits under this claim to be paid directly to San Diego Center for GYN Oncology, I understand that I am responsible for the charges not covered by this authorization. **Cancellation Policy:** There is a $35.00 charge for not cancelling or rescheduling appointment at least 24 hours in advance.

_____
Patients Signature Date

SAN DIEGO CENTER for GYN ONCOLOGY

New Patient Encounter

Date of visit: _____

Name: _____ DOB:_____

By whom were you referred? _____ His/Her specialty:_____

Referring Dr.'s phone #: _____

Are there any other physicians (e.g primary care) with whom you would like your consultation discussed?

Doctor/Specialty Phone #

_____ _____

_____ _____

For what reasons were you referred?

_____

_____

List any ultrasounds, CT scans, MRI's, biopsies, or blood test that have already been done (related to the above).

_____

Please check any symptoms you are currently having:

☐ Chest pain/Palpitations ☐ Cough/Shortness of breath ☐ Nausea/Vomiting

☐ Problems with urination ☐ Blood in urine/Stool/Sputum ☐ Vaginal bleeding/Discharge

☐ Loss of appetite ☐ Fever/Chills/Night sweats ☐ Excessive weight gain or loss

☐ Headache/Dizziness ☐ Fatigue/Malaise

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Daily Habits

Smoke:	☐ ¼ pack	☐ ½ pack	☐ 1 pack	☐ Other	☐ Never
Alcohol:	☐ Social	☐ Minimal	☐ Moderate	☐ Occasional	☐ Never
Drugs:	☐ Past	☐ Present	☐ Recovering	☐ Occasional	☐ Never

Personal History

Are you sexual active? ☐ Yes ☐ No

Has there been a change in your sexual desire? ☐ Yes ☐ No

Have you had problems with vaginal dryness? ☐ Yes ☐No

Date of last pap smear:_____ Any abnormal?_____ When_____

Treatment:_____

Date of last mammogram:_____ Any abnormal?_____ When_____

Treatment:_____

Would you have a blood transfusion if needed? ☐ Yes ☐ No

Heart /Circulation

Do you get palpitations (feel your heart pounding)? ☐ Yes ☐ No

Do you get leg cramps that go away when you stop and rest? ☐ Yes ☐ No

Have you ever had phlebitis or blood clots in your leg? ☐ Yes ☐ No

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Place a check mark next to the condition if any blood relative has had any of the following conditions. Write which relative has the condition. Ex. ☐ anemia-mother

☐ Anemia
☐ Chronic lung disease
☐ Mental illness
☐ High blood pressure
☐ Seizures
☐ Other
☐ Repeated infections
☐ Heart disease
☐ Tuberculosis
☐ Asthma
☐ Thyroid troubles
☐ Bleeding tendency
☐ Leukemia
☐ Kidney disease
☐ Skin cancer
☐ Diabetes

Skin:

Do you have or have you had problems with:

☐ Rashes ☐ Scars ☐ Jaundice ☐ Burns
☐ Moles ☐ Lumps ☐ Bruises ☐ Itches
☐ Wounds ☐ Ulcers ☐ Sores ☐ None

Do you bruise easily? ☐ Yes ☐ No

Lungs:

Do you ever sit up at night to catch your breath? ☐ Yes ☐ No
Do you have to prop yourself up to sleep? ☐ Yes ☐ No
How many pillows do you sleep on? ☐ 1 ☐ 2 ☐ 3 ☐ 4

Choose on:
☐ I have no shortness of breath walking on level ground at a normal pace.
☐ I can walk as long as I want provided I walk slowly.
☐ I must stop and rest after one or two blocks.
☐ I must stop and rest going from room to room in the house.
☐ I am short of breath just sitting.

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Reproductive System:

Do you have or have you had problems with:

☐ Infections	☐ Painful intercourse	☐ Bleeding after douching
☐ Discharge	☐ Venereal disease	☐ Bleeding after intercourse
☐ Itching	☐ Warts	☐ Intermenstrual bleeding
☐ Herpes	☐ Pelvic pressure	☐ Post menopausal bleeding
☐ Hot flashes	☐ Vaginal dryness	

Menstrual History

Age at onset of period:_____
Date of last menstrual period:_____ ☐ Normal ☐ Heavy ☐ Irregular
Are there any changes in your menstrual cycle? ☐ Yes ☐ No
Explain:_____
Are your periods becoming heavier and painful? ☐ Yes ☐ No
Have you seen a physician about this issue before? ☐ Yes ☐ No
When?_____ Treatment given?_____

Obstetrical History

Age at first pregnancy:_____ Age at last pregnancy:_____
Number of pregnancies:_____ Caesarean vs. Vaginal:_____
Number of abortions:_____ Complications:_____

Sexual/Contraceptive History

Age at first intercourse:_____ Number of sexual partners in a lifetime:_____
Previous birth control uses:_____ Pelvic inflammatory disease:_____
Sexually transmitted disease?_____

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Pain

Do you have any pain or discomfort? ☐ Yes ☐ No
If yes: Location_____ When did it start?_____
How long does it last?_____ How often does it occur?_____
What makes it better?_____ What makes it worse?_____
Describe the pain: Is the pain ☐ Burning ☐ Aching ☐ Other:_____
What impact does your pain have on daily activities? ☐ Little ☐ Moderate ☐ Major
Please use this Zero to Ten Scale (0-10) to rate your pain or discomfort

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain					Worst Possible Pain

Symptoms

		Comment
Do you have nausea or vomiting?	☐ Yes ☐ No	_____
Do you have fatigue?	☐ Yes ☐ No	_____
Do you have anxiety or feel nervous?	☐ Yes ☐ No	_____
Do you have forgetfulness or confusion?	☐ Yes ☐ No	_____
Do you feel depressed?	☐ Yes ☐ No	_____
Do you have any problems with sleeping?	☐ Yes ☐ No	_____
Do you have headaches?	☐ Yes ☐ No	_____
Do you have chest pain?	☐ Yes ☐ No	_____
Do you have numbness or tingling?	☐ Yes ☐ No	_____

Diet

What type of diet are you on at home? ☐ Regular ☐ Special or Diabetic
☐ Nutrition through IV ☐ Tube Feeding
Have you had any unplanned weight change? ☐ Yes ☐ No
If yes:_____pounds ☐ Lost ☐ Gained Since when?_____
Have you had any loss of appetite? ☐ Yes ☐ No
Have you had any difficulty swallowing? ☐ Yes ☐ No
Do you have dentures or partials? ☐ Yes ☐ No
Do you have any questions for someone about nutrition? ☐ Yes ☐ No
Please list any cultural or ethnic food choices or restrictions:_____

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Elimination

Do you have any problem urinating? ☐ Yes ☐ No
If yes, please check all that apply: ☐ Frequency ☐Urgency ☐ Pain or Burning
☐ Dribbling or Incontininence ☐Other:_____
Do you have a urostomy bag or pouch for urine? ☐ Yes ☐ No Cared by:_____

Bowel Habits

How often do you have a bowel movement?_____
When was your last bowel movement?_____
Do you use anything to assist your bowel movements? ☐ Yes ☐ No I use:_____
Please check any of the following that apply to your bowel movements:
☐ Diarrhea ☐ Constipation ☐ Ostomy: Care for by:_____

Safety, Communication and Movement

Have you had any of the following:
☐ I have weakness
☐ I have painful numbness and tingling
☐ I have fallen in the past 3 months
What happened?_____
☐ I use a splint, brace, or some kind of equipment
☐ I have some limited problem with my hand or arm
☐ I am unable to speak my wants or needs
☐ I have memory problems or problems thinking clearly
☐ I have difficulty swallowing
☐ I have difficulty walking
☐ I need help with walking and moving around
☐ I have none of the above problems

Do you have any of the following:
☐Glasses/Contacts
☐ Pacemaker/Internal Defibrillator
☐ Hearing Aid(s)
☐ Other prosthetic devices_____
☐ I use none of the above devices

Other Personal Health and Habits

Have you had any of the following:

History of Tuberculosis (TB)?	☐ Yes	☐ No
Exposure to a person with TB?	☐ Yes	☐ No
History of a positive TB test?	☐ Yes	☐ No
Fevers?	☐ Yes	☐ No
Sweating at Night?	☐ Yes	☐ No
Cough for 3 weeks or longer?	☐ Yes	☐ No
Coughing up blood?	☐ Yes	☐ No
Have you had a flu vaccine?	☐ Yes	☐ No
Have you had pneumonia vaccine?	☐ Yes	☐ No
Have you had a blood transfusion?	☐ Yes	☐ No

Did you have a reaction to the blood transfusion? ☐ Yes ☐ No If yes what happened_____

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Emotional, spiritual and Cultural Care

Have you had any recent major life changes? ☐ Yes ☐ No
If yes: Please describe_____
Are you having difficulty coping? ☐ Yes ☐ No
If yes: Please describe_____
Do you have any: cultural beliefs, religious or ethnic needs that we need to know about before we can care for you?
If yes: Please describe_____

Planning for Care at Home

Who do you live with?_____
Who can assist you with care, if needed?_____ Phone_____
Please list any medical equipment and/or home care agency you use at home;_____
Where do you live? ☐ House ☐ Apartment ☐ Extend Care Facility ☐ Other_____
Do you have any stairs you have to climb? ☐ Yes ☐ No

Learning

Do you have any learning challenges? ☐ Yes ☐ No
What are the best ways you learn new things? ☐ Seeing ☐ Hearing ☐ Doing ☐ Reading
Do you have any problems with your memory, or with your emotional or physical health that gets in the way of learning ☐ Yes ☐ No
If yes: Please describe_____
Does anything make learning difficult for you? ☐ Yes ☐ No
If yes: Please describe_____

Advance Directives

Do you have any of the following?

☐ Durable Power of Attorney for Healthcare ☐ Living Will

☐ DNR Comfort Care (Do Not Resuscitate) ☐ DNR (Do Not Resuscitate)

☐ I do not have any of the above, but would like more information
If you have any of these documents, please bring a copy to the hospital with you.

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Height:_____ Weight:_____

LIST PRESCRIBED MEDICATIONS & OVER THE COUNTER DRUGS & VITAMINS

Drug name and strength	Why you take it	Directions on bottle

ALLERGIES TO MEDICATIONS

Name of Drug	Reaction you had

SURGERY

Surgery/Month Year	Reason & Complications	Hospital/Doctor

SAN DIEGO CENTER for GYN ONCOLOGY

Dr. Kris Ghosh, MD & Dr. Sue Ghosh, MD

955 Boardwalk St. #100 San Marcos Ca 92078 ph (760) 471-0200 fx (760) 471-0211

Permission to Furnish Information

Please list persons to whom we may furnish medical information about you (Example: blood test result, doctor's instructions, etc) in the event you are not immediately available. Unless otherwise indicated, we will leave a message on your answering machine or voice mail with any routine results or instructions when you are not available.

This Authorization Will Be in Effect Until Revoked in Writing

_____ Initial here if you wish us to furnish information ONLY to you. In this instance, we will leave a message for you to call our office if you are not available.

Approved Person (s)	Relationship to you
_____	_____
_____	_____
_____	_____

_____ Patient Name (please print)

_____ Date of Birth

_____ Signature

_____ Date