For Women By Women
Rosanne Mayhew, M.D.

Gynecology and Women's Health

PO Box 320693 Los Gatos, CA 95032
Phone 408.871.1885 Fax 408.871.8405

I hereby authorize/disclose my records to:_____
(OTHER PHYSICIAN'S NAME)
Dr Rosanne Mayhew at PO Box 320693, Los Gatos, CA 95032

DURATION : This authorization shall become effective immediately and shall remain in effect until_____or for one year from the date signature.

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization .

RE-DISCLOSURE : II understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY: Check and initial to specify which type of information is to be disclosed

RECOR DS: MEDICAL INFORMATION _____
DRUG/ ALCOHOL INFORMATION _____
PSYCHIATRIC IN FORMATION _____
RESULTS OF AN HIV BLOOD TEST _____
OTHER HEALTH INFORMATION _____

SPECIFY THE RECORDS TO BE DISCLOSED:

_____

_____

_____

The requester may use the health information authorized on this form for the following purposes only:

_____

_____

DATE: _____ SIGNATURE: _____

NAMEOFPATIENT:_____

Medical Information

Name: _____ D.O.B. _____

Personal History

Have you had...	Yes	No	Don't Know
1. High Blood Pressure	☐	☐	☐
2. Diabetes	☐	☐	☐
3. Thyroid Disease	☐	☐	☐
4. Anemia	☐	☐	☐
5. Cancer (Female, Skin)	☐	☐	☐
6. Genital Warts/HPV	☐	☐	☐
7. Gardasil Vaccination	☐	☐	☐
8. Yeast Infections	☐	☐	☐
9. Bladder Infections	☐	☐	☐
10. Gonorrhea or Syphilis	☐	☐	☐
11. Chlamydia	☐	☐	☐
12. Heart Disease	☐	☐	☐
13. Heart Murmur	☐	☐	☐
14. Chest Pain	☐	☐	☐
15. Gall Bladder Disease	☐	☐	☐
16. Stomach Trouble/Ulcer	☐	☐	☐
17. Rectal Bleeding	☐	☐	☐
18. Kidney Infection	☐	☐	☐
19. Hepatitis	☐	☐	☐
20. Herpes	☐	☐	☐
21. Sleep Problems	☐	☐	☐
22. Migraine Headaches	☐	☐	☐
23. Epilepsy (convulsions)	☐	☐	☐
24. Nervous Breakdown	☐	☐	☐
25. Breast Disease	☐	☐	☐
26. German Measles	☐	☐	☐
27. Pneumonia	☐	☐	☐
28. Tuberculosis	☐	☐	☐
29. Rheumatic Fever	☐	☐	☐
30. Thrombophlebitis	☐	☐	☐
31. Varicose Veins	☐	☐	☐
32. Arthritis	☐	☐	☐
33. Mammogram	☐	☐	☐
34. Chicken Pox/Shingles	☐	☐	☐
35. Asthma	☐	☐	☐

Gynecologic History

Menses

Age of Onset _____

Regular? ☐ Yes ☐ No

Cycle Length _____ days

Duration of Flow _____ days

Flow ☐ Light ☐ Medium ☐ Heavy

Pain or Cramps ☐ Yes ☐ No

Treatment of Cramps _____

Date of First Day of Last Period _____

Date of Last Pap Smear _____

Previous Abnormal Pap Smear? ☐ Yes ☐ No

Contraceptive Method Now and Previous Methods w/Dates

Birth Control Pills _____

Diaphragm _____

Intrauterine Device _____

Do you Breast Self-Exam? ☐ Yes ☐ No

Pregnancy History (include terminations and miscarriages)

Year	Baby's Weight	Sex	Type of Delivery	Complications
____	_____	____	_____	_____
____	_____	____	_____	_____
____	_____	____	_____	_____
____	_____	____	_____	_____
____	_____	____	_____	_____
____	_____	____	_____	_____

Height _____

Weight Now _____

Weight One Year Ago _____

Highest Weight (excluding Pregnancy) _____

PAST HISTORY

Current Medications _____

Allergies to Medicine _____ Type of Reaction _____

_____

Transfusions

Surgery

Type, date & place

(including cryosurgery on cervix) _____

_____

Hospitalizations

Reasons, date & place _____

_____

FAMILY HISTORY

	Living		Deceased	
	Age	Health Problems	Age	Cause
Mother 1				
Father 2				
Brother/Sister 3				
4				
5				
Husband 1				
Son/Daughter 2				
3				
4				

HAS ANY RELATIVE HAD:	YES	NO	WHO
1. Breast Cancer	☐	☐	_____
2. Other Cancer	☐	☐	_____
3. Tuberculosis	☐	☐	_____
4. Thyroid Disease	☐	☐	_____
5. Diabetes	☐	☐	_____
6. Heart Disease	☐	☐	_____
7. High Blood Pressure	☐	☐	_____
8. Stroke	☐	☐	_____
9. Epilepsy	☐	☐	_____
10. Suicide	☐	☐	_____
11. Mental Illness	☐	☐	_____
12. Kidney Disease	☐	☐	_____
13. Birth Defects	☐	☐	_____
14. Twins	☐	☐	_____
15. Bleeding Disorder	☐	☐	_____

SOCIAL HISTORY

Alcohol: Type _____ Quantity _____

Cigarettes _____ pack/day

Caffeine _____ cups/day

Drugs _____

Daily Exercises ☐ Yes ☐ No

Type _____

Occupation _____

Signature: _____

Date: _____

for Women by Women

Please List All Medications And Supplements

Prescription For: _____ Date: _____

MEDICINE	DOSAGE	NUMBER OF TABLETS TO BE TAKEN AT: 7A -9A	11A-1P	4P-6P	9P-11P	DOCTOR

ALLERGIES:

NOTES:

Financial Policy

Welcome to For Women By Women. My staff and I are here to serve your healthcare needs and are dedicated to providing you the best care possible. It is important you understand that For Women By Women puts you, and not your health insurance company, in charge of your healthcare. Please read and sign the following statement of our financial policy. If you have any questions regarding our billing policies please be sure you have a satisfactory answer before signing this document.

Thank You,
Rosanne Mayhew, M.D.

INSURANCE:
Health insurance policy provisions have for some time dedicated what services can be provided. the timing of those services, and the reimbursement rate for services. Not only have these provisions adversely impacted the quality of care, they have also reduced the doctor-patient relationship to an occasional brief encounter. We feel our patients deserve better.
Your individual insurance plan is an agreement between you and your health insurance company. It is your responsibility to know the specific details of your own plan. It is especially important for you to let us know if there are restrictions regarding referrals, labs,or services to be performed by outside facilities or specialists. You may be responsible for charges if they are not contracted with your insurance company or you have not received proper preauthorization. You will also be responsible for any "Non-Covered Services." Currently our office is not contracted with any insurance companies. Your account will be considered a self pay account with full payment expected at the time of service. You will be provided with the documentation necessary to bill your insurance company.

BILLING:
Cash or check payers receive a 20% discount from our normal fee schedule. Credit card payers receive a 15% discount from our normal fee schedule. NOTE: This discount does not apply to laser/cosmetic treatments which are quoted at the cash discount rate. Cosmetic procedures (incl. products) are subject to a 5% convenience fee for payments by credit card.

LASER & COSMETIC:
Please note that laser and other cosmetic treatments always require payment in full at the time of service and there is NO assurance that you will be reimbursed by your insurance plan. Sales of all cosmetic products are final and may not be returned for any reason. WE DO NOT ACCEPT ANY INSURANCE PAYMENTS FOR LASER TREATMENTS.

ACCOUNT FEES:
Past due payment balances may incur the greater of a $20 billing charge per month or interest at an annual rate of 18%. A fee of $30 will be charged for each returned check.

RECORDS & FORMS:
The completion of the physician section of disability forms or health forms will incur a $50 administrative charge. Duplication of medical records is $30-$50 depending on chart size and or postage.

PATIENT INFORMATION:
You will be asked to fill out a patient information form at your initial visit and each year thereafter. In order to keep your file up to date, please inform us of any changes of information such as insurance, address and telephone number.

MISSED APPOINTMENTS:
Unless canceled at least 24 hours in advance, you may be charged $50 for missed appointment. Please help us serve our patients better by keeping scheduled appointments.

I have read and understand the above stated Financial Policy and freely accept financial responsibility whether or not any service is covered by my insurance. I also understand that this Financial Policy is subject to change without written notice. Changes will be posted in the office.

Signature: _____ Date: _____

Print Name: _____ Update 6/15

drmayhew.com ❧ P.O. Box 320693, ❧ Los Gatos, California 95032
T: 408.871.1885 ❧ F: 408-871.8405 ❧ G. Voice: 408.359.7130

REGISTRATION FORM
PLEASE PRINT

DATE: _____

PATIENT NAME: _____ AGE: _____ SS# _____
(last) (first)

ADDRESS: _____ PHONE #: _____
(House Number, Street Name, City, State, Zip Code) Please indicate Home or Cell

DATE OF BIRTH: _____ MARITAL STATUS: S M D SEP DRIVERS LIC: _____

EMAIL ADDRESS: _____

EMPLOYER: _____ WORK PHONE: _____

SPOUSE OR SIG. OTHER: _____ SS#: _____ DOB: _____

EMPLOYER: _____ WORK PHONE: _____

NEAREST RELATIVE/EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

REFERRED BY: Name _____ Address _____

Please check one: ☐ Doctor ☐ Friend ☐ Ins. Book ☐ Yllw Pgs. ☐ Other _____

COPY OF INSURANCE CARD Subscriber's Date of Birth (if different from patient): _____

If necessity arises, I hereby authorize the release of any medical information needed to process insurance claims and request that payment of benefits be made to ROSANNE MAYHEW, M.D.. I also give authorization for ANY hospital to release any medical information obtained in the course of my admission. The disclosure of records is required for the continuation of my care. I understand that I am financially responsible for all charges incurred whether or not covered by insurance.

SIGNATURE: _____ DATE: _____

If patient is a minor, please indicate the person responsible:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ HOME PHONE: _____