

ESSAM TAYMOUR, M.D.
GYNECOLOGY AND OBSTETRICS MEDICAL GROUP, INC
3550 LINDEN AVE #1
LONG BEACH, CA 90807
(562) 595-5331
FAX (562) 595-1335

We are honored that you have chosen our practice to receive your gynecological care. We would like to simplify the processing of paperwork on the day of your visit by enclosing our new patient information forms. Please complete these forms and bring them with you at the time of your visit.

Please note that we do charge \$50 for missed appointment. We ask that you give us advanced notice if you cannot keep your appointment.

If you have insurance, please bring your card with you on the day of your appointment as well as a picture ID. If you do not have insurance or you have a co-pay/cost share, we accept cash, Mastercard, Visa, Discover and checks.

Co-pays are due at the time of your visit.

If you have any questions at any time please feel free to contact our office.

Thank you for the opportunity to provide you with excellent medical care.

Sincerely,

Dr. Essam Taymour and Staff

ESSAM TAYMOUR, M.D.

1550 Linden Ave., #1, Long Beach, CA 9080

PATIENT INFORMATION (please print)

Appointment Date.

Name: _____

Sex: ☐ Female ☐ Male

Address: _____

Date of Birth: _____ Age: _____

City, State, Zip: _____

Social Security #: _____

Driver's License/ID #: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced

Email Address: _____

Will you allow us to send internet based (email) delivery of reminders and newsletters? ☐ Yes ☐ No

Race: ☐ American/Alaskan Indian ☐ Asian ☐ Black ☐ Caucasian ☐ Pacific Islander ☐ Declined

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined Language: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Other Phone: _____

Who referred you to us/How did you hear about us? _____

Primary Physician: _____

Phone: _____

Employer/Occupation: _____

Phone: _____

GUARANTOR RESPONSIBLE PARTY

☐ Patient

☐ Other:

Relationship:

Name: _____

Employer: _____

Address: _____

Phone: _____

Social Security #: _____

City, State, Zip: _____

Date of Birth: _____

INSURANCE – YOU MUST PROVIDE ANY & ALL INSURANCE INFO OR YOU WILL BE LIABLE FOR CHARGES NOT COVERED. INITIALS

Primary Ins Co: _____

Name of insured: _____

Relationship to patient: _____

Date of birth of insured: _____

Insured ID/Cert #: _____

Secondary Ins Co: _____

Name of insured: _____

Relationship to patient: _____

Date of birth of insured: _____

Insured ID/Cert #: _____

EMERGENCY CONTACT

Name: _____

Street Address: _____

City, State, Zip: _____

Relationship: _____

Phone: _____

Durable Power of Attorney for Health Care (California civil code section 2500): Do you have or wish to have an appointed representative to carry out your wishes concerning your health care/treatment in the event of an emergency rendering you unable to make such decisions? ☐ Yes, I have a representative. Name of representative _____

Phone #: _____. Please provide copy of certificate.

☐ No, I do not have a representative. ☐ Please give me the information on how to appoint myself a representative.

I hereby assign the insurance benefits to which I am entitled, directly to Gynecology & Obstetrics Medical Group. I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as the original.

I consent to treatment as necessary or desirable including but not restricted to whatever drugs, medicine, performance of operations or procedures and conduct of laboratory, x-rays or other studies that may be used by the attending physician or his/her nurse or qualified designate.

This agreement will remain valid from this day forward to include all future services relating to the above patient.

Signature

Date

Name: _____ Age _____ Date _____

Family History

Family History	If living		If deceased		Has any relative ever had	No Yes		Who
	Age	Health	Age	Cause				
Father					Cancer	☐	☐	
Mother					Tuberculosis	☐	☐	
Brother or Sister 1					Diabetes	☐	☐	
2					Heart trouble	☐	☐	
3					High blood pressure	☐	☐	
4					Stroke	☐	☐	
5					Epilepsy	☐	☐	
Husband					Suicide	☐	☐	
Son or Daughter 1					Mental illness	☐	☐	
2					Hysterectomy	☐	☐	
3					Cesarean section	☐	☐	
4					Kidney trouble	☐	☐	
5								

Menstrual History

Age of onset _____
 Regular ☐ yes ☐ no
 Cycle _____ days (from start to start)
 Usual duration _____ days
 Flow ☐ light ☐ moderate ☐ heavy
 Pains or cramps ☐ yes ☐ no
 Date of last period _____

List pregnancies (include miscarriages)

Year	Weight	Sex	Hrs of labor	Anesthesia	Complications

PERSONAL HISTORY

Weight: Now _____ 1 yr ago _____ Highest _____ When _____

Have you ever had:	No	Yes	Do you now have or have you ever had:	No	Yes
German measles	☐	☐	Any eye diseases, injury, impaired sight	☐	☐
Mumps	☐	☐	Any ear diseases, injury, impaired hearing	☐	☐
Chicken pox	☐	☐	Any trouble with nose, sinuses, mouth, throat	☐	☐
Scarlet fever	☐	☐	Any head injury, fainting spells, convulsions	☐	☐
Diphtheria	☐	☐	Frequent or severe headaches	☐	☐
Pneumonia	☐	☐	Skin disease	☐	☐
Rheumatic fever	☐	☐	Chronic or frequent cough	☐	☐
Heart disease	☐	☐	Chest pain or spitting up of blood	☐	☐
Heart murmur	☐	☐	Night sweats	☐	☐
Polio or meningitis	☐	☐	Shortness of breath	☐	☐
Kidney infections	☐	☐	Swelling of hands, feet or ankles	☐	☐
Gonorrhea or syphilis	☐	☐	Varicose veins	☐	☐
Anemia	☐	☐	Kidney or bladder disease	☐	☐
Jaundice	☐	☐	Indigestion, stomach trouble or ulcer	☐	☐
Gallbladder disease	☐	☐	Rectal bleeding, constipation or diarrhea	☐	☐
Epilepsy	☐	☐	Loss of urine with cough or sneeze	☐	☐
Migraine headaches	☐	☐	Alcoholic Beverages ☐ never ☐ moderate ☐ daily		
Tuberculosis	☐	☐	Cigarettes _____ pack per day		
Valley fever	☐	☐	Surgery – what, when, where _____		
Cancer	☐	☐			
High or low blood pressure ☐	☐	☐	Allergies: _____		
Nervous breakdown	☐	☐	Transfusions ☐ no ☐ yes Number _____		
Diabetes	☐	☐			

PATIENT NAME:

DATE:

CURRENT MEDICATIONS	REASON	CURRENT MEDICATIONS	REASON

**PREFERRED PHARMACY PHONE #:

REFILLS (FOR OFFICE USE)

[illegible]

PAYMENT POLICY
ESSAM TAYMOUR M.D.
GYNECOLOGY & OBSTETRICS MEDICAL GROUP, INC.

Co-payment must be paid at the time services are provided. In the case of surgery we expect that the patient responsibility portion will be paid prior to hospitalization, unless other arrangements are made with our billing office. We accept Visa, Mastercard, Discover, debit, personal check, money order or cash.

We do charge \$50 for missed appointments. We ask that you give us advanced notice if you cannot keep your appointment to avoid being charged \$50.

Please be aware that authorization does not guarantee payment. Payment from the insurance company is determined upon receipt of the claim and if coverage is in effect at the time of service. In the event that your insurance company does not pay/respond for services provided you are financially responsible for the balance due.

Infertility even if authorized may be limited or not a benefit of your plan. So please always refer to your insurance directly for all services in question.

We take every measure to avoid sending our patients to collections. In the event that we need to contact you regarding your balance and we cannot reach you by mail, email or phone, is there anyone you want us to notify that we need to reach you.

Name: _____ Phone# _____

Address: _____

There is a \$50.00 fee that will be applied when your account is sent to a collection agency.

I have read the above payment policy for GYNECOLOGY & OBSTETRICS MEDICAL GROUP, INC.

Patient Name: _____

Patient, Parent or Guardian Signature: _____

Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

ESSAM TAYMOUR, M.D.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, communicable diseases; health oversight; abuse or neglect. Food and Drug Administration requirements: Legal Proceedings: law enforcement; coroners, funeral directors and organ donation; criminal activity, military activity, national security; workers' compensation; Inmates: required uses and disclosures: Under the law, we must make disclosures to you and when by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records, psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health & Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print name _____ Signature _____ Date _____



Cancer Risk Assessment

Patient Name _____ Date of Birth ____/____/____ Date Completed ____/____/____

This is a screening tool for the common features of hereditary cancer. Our service will allow us to give you the most technologically advanced screening possible to increase the chances of cancer detection and early intervention to optimize your health.

Circle Y for those that apply to **YOU and/or YOUR FAMILY** (consider all relatives on both mother's and father's side). **YOU AND THE FOLLOWING CLOSE BLOOD RELATIVES SHOULD BE CONSIDERED.** *Mother, Father, Sister, Brother, Sons, Daughters, Half-Siblings, Aunts, Uncles, Grandparents, Nieces, Nephews, Cousins, Great Grandparents, Great Aunt/Uncle*

CANCER		SELF/ SIBLING AGE AT DIAGNOSIS	RELATIONSHIP TO FAMILY MEMBER w/ CANCER	
			MOTHER or Relatives on MOTHER's side (Aunts, Uncles, Grandparents, Nieces, Nephews, Cousins)	FATHER or Relatives on FATHER's side (Aunts, Uncles, Grandparents, Nieces, Nephews, Cousins)
	EXAMPLE:	Me 35 Sister 40	Aunt 35	Grandmother 75
Y	N	Colon Cancer before Age 50?		
Y	N	Endometrial Cancer before Age 50?		
Y	N	Two or more of the following cancers in the same person or on the same side of the family at any age? (Lynch syndrome cancers: uterine, colon, ovarian, stomach, ureter, small bowel, pancreas, brain)		
Y	N	Ten or more lifetime colon polyps?		
Y	N	Ashkenazi Jewish ancestry with breast or ovarian cancer in a family member at any age?		
Y	N	Ovarian cancer at any age?		
Y	N	Male breast cancer at any age?		
Y	N	Breast Cancer before age 50?		
Y	N	Pancreatic Cancer at any age?		
Y	N	Two breast cancers on the same side of the family with one diagnosed before age 50?		
Y	N	Three or more breast cancers on the same side of your family diagnosed at any age?		
Y	N	Combination of three or more of the following cancers on the same side of the family diagnosed at any age? Pancreatic, prostate, breast or ovarian cancers.		
Y	N	Any other Cancers?		

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ☐ Yes ☐ No

Patient signature: _____ Date: _____

For Office Use Only:

Reason for Decline:

Patient offered testing ☐ Accepted ☐ Declined

Patient MRN# _____ Provider Signature _____

FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sleep Problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	☐	☐	☐	☐	☐
Decline in drive or interest (loss of "zest for life," feeling down or sad)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Vaginal dryness or difficulty with sexual intercourse	☐	☐	☐	☐	☐
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hot Flashes (burst that starts in chest and lasts for short duration)	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feeling cold all the time, having cold hands or feet	☐	☐	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐	☐	☐
Weight (difficulty losing weight despite diet/exercise)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take into consideration:
