CHARLES W. MONIAK, M.D.
Rachael Duran, MSN, FNP-C

OBSTETRICS●GYNECOLOGY
320 Superior Ave, Suite 230; Newport Beach, CA 92663

PATIENT DEMOGRAPHICS
-Please Print/ Fill Out Each Section Completely -

Name (Full Legal Name) : ____
First Middle Last (all used)

Other names used: ____

Last 4 digits of SS: -__________ DOB: _______/________/______ Age: ________ Height: ________ Weight: ________

Ethnicity: ________________________________ (used for genetic screening) Language Preferred: ______________

Street Address: ____ City: __________________________

State: ________ Zip Code: _______ Phone: (___)_____-__________E-mail:_________________________

☐ Please check this box if it is OK to leave medical information/test results on voicemail associated with phone number.

☐ Please check this box if you consent to remote or tele-health visits when necessary.

Insurance Information: Group/Plan:__________________________ Member ID____________________

If insured under family member, please list insured policy holder info below:

Name: ____ DOB:______/________/_______
First Middle Last

Relationship to patient:☐ Spouse ☐ Parent ☐ Other

Please Provide Pharmacy Information Below:

Pharmacy name:____

Pharmacy city/address: ____

Pharmacy phone number:____

Significant Other/Emergency Contact Information:

Name:___________________________________ Phone: _____________ Relationship: _________________

Alternative: _______________________________ Phone: _____________ Relationship: _________________

Ok to discuss medical information with this person (if you wish to revoke this please request in writing) ☐YES ☐ NO

REASON FOR YOUR VISIT TODAY:____

Whom may we thank for your referral ? ____

Gynecological History**:** (Please update as applicable) Primary Care Doctor: ________________________________

Last Menstrual Period ___________________________ (please complete)

Last Bone Density Exam ________ (year)

Last Colonoscopy ______________(year)

Last Mammogram ______________(year)

Last Pap Smear ________________(year)

HPV/Gardasil Vaccine Series Completed ☐ YES ☐NO

Hepatitis B Vaccine Series Completed ☐ YES ☐ NO

History of Abnormal Pap Smears? ☐YES ☐ NO ☐ UNKNOWN

Treatment of Abnormal Pap Smears? (List Dates if known)

LEEP ___________________

Cryo (freezing) ____________

Laser ____________________

Biopsies _________________

Menstrual History: Age of First Period__________ If Menopausal, Age of Last Period ____________

Are your cycles: ☐ REGULAR ☐ IRREGULAR

Are you sexually active: ☐YES ☐NOT CURRENTLY ☐NEVER

Method of Contraception: ____

Medical History: Do you now or have you *ever* had?

☐ Asthma

☐ Autoimmune Disorder (list below)

____

☐ Bleeding Disorder

☐ Blood Transfusion

☐ Bone/Joint Disease

☐ Cancer (list below)

____

☐ Chicken Pox

☐ Chlamydia

☐ Deep Vein Thrombosis (DVT)

☐ Depression

☐ Diabetes

☐ Elevated Cholesterol

☐ Endometriosis

☐ Fibroids

☐ GERD/Reflux

☐ G.I. Conditions

☐ Gestational Diabetes

☐ Gonorrhea

☐ Heart Disease

☐ Hepatitis (list type)

____

☐ Herpes Infection

☐ Infertility

☐ HIV

☐ HPV/Genital Warts

☐ High Blood Pressure

☐ Liver Disease

☐ Migraines

☐ Osteopenia/porosis

☐ Pelvic Inflammatory Disease

☐ Seizures

☐ Sleep Apnea

☐ Syphilis

☐ Thyroid Condition

☐ Trauma/Violence

☐ Tuberculosis

☐ OTHER (list below)

____

LIST ALL ALLERGIES:____

____

List *ALL* Medications and Dosage Taken Below:

Drug/Dose	**Purpose**	**Drug/Dose**	**Purpose**

Example: Synthroid 100mcg daily, Hypothyroid

1.____________________________________ 6.____________________________________

2.____________________________________ 7. ____________________________________

3.____________________________________ 8. ____________________________________

4.____________________________________ 9. ____________________________________

5.____________________________________ 10. ___________________________________

Surgical History: List all surgeries, date preformed and/or complications.

Surgery	Date Performed	Complications (If Any)

Social History: Occupation____

☐ Married ☐ Single ☐ Divorced ☐ Widowed Other:________________________________

Tobacco Use? ☐ YES ☐ NO ☐ In the Past

Alcohol Use? ☐ Daily ☐ A few times a week ☐ Occassionally ☐ Never/Sober

Drug Use? ☐ YES (*list drug(s) and last use*)____________________ ☐ NO ☐ In the Past

***Obstetrical History*: (**Please include **all** pregnancies, including miscarriages, abortions, ectopic pregnancies and pre-term)

Estimated Date of Delivery (if known): ____

Birthdate (month/day/year)	***Weeks at delivery***	***Length of Labor (hours)***	***Baby Weight (pounds)***	***Sex***	***Type of Delivery***	***Complications***	***Location***
EXAMPLE 08/05/2015	**39weeks**	**36 hours**	**6lb 12 oz**	**F**	**Vaginal**	**Gestational Diabetes**	**Hoag**
Please Complete. →	Total Miscarriages=		Total Ectopic =		Total Induced Abortion =		

Family History:

Please include the age of onset and type of cancer if known.

ILLNESS	***Mother***	***Father***	***Brother***	***Sister***	***Maternal Grandmother***	***Maternal Grandfather***	***Paternal Grandmother***	***Paternal Grandfather***	***Other Relative***
Cancer (type)									
Diabetes (type)									
Heart Disease									
Bleeding Disorders/ Blood clots									
Other									

Office Policies and Important Information

- You are a participant in your health care. We look forward to collaborating on the best version of health for you as an individual. You make up half of your health care team. We encourage questions and regular health visits. Annual well woman visits are still recommended and required for medication refills.

- All appointments scheduled are for *either* available medical provider (NP or MD) unless otherwise stated. We are confident our experienced Nurse Practitioner, Rachael Duran MSN, FNP-C can meet your needs in the absence of Dr. Moniak. Rachael has exclusive training and brings a wealth of additional talents to our provider table with experience in emergency medicine, critical care and women's health. If you have a preference in provider (female provider or doctor only) please make this request at the time of scheduling. We will do our best to accommodate your request without guarantee.

- Our regular office hours are 9am – 5pm Monday through Friday. Office visits are scheduled between 9am to 11:30am and 1pm -4pm. If you are more than 15 minutes late for your appointment your appointment may be rescheduled. Co-pay fees may still apply to late or missed appointments.

- Co-payments are due at the time of your visit. You are responsible for any charges or fees that remain after insurance has been applied. If there is any question about fees for services rendered, please contact your insurance company first to establish your coverage and benefits. An approved authorization for services is not a guarantee of payment from insurance. Any fees outside of your insurance are due at the time of services rendered.

- If you are an obstetrical patient, ultrasounds are generally paid by insurance up to one time. Your insurance may vary and if there is a fee for ultrasound in pregnancy you are responsible for this charge. Our office does three standard ultrasounds at 10weeks, 20 weeks and 36 weeks. If any additional ultrasounds are needed or scheduled you are responsible for any charges not paid by insurance at the time services are rendered.

- We love watching your families grow and change, however this is a medical practice concerned with keeping our patients safe and healthy. We ask that you leave children at home and do not bring additional guests to the office to minimize exposure and maximize health of our patients. You are welcome to bring one support person with you to visits. We appreciate your understanding.

- Our practice loves to answer questions and be your health resource. However, phone calls returned by one of our providers may incur additional charges for tele-medicine or out of pocket fees for phone/video consults, questions, detailed lab review, or symptom management. Symptoms of vaginal infection or urine infection are always asked to come in for appropriate testing and culture.

- If you have a need for over 3 months of continued regular prescriptions for pain medication or controlled substances, you may be referred to pain management or other specialty. If for some reason your medication is refilled by our providers, an office visit is required every three months to re-evaluate. You may be asked to sign a pain contract if pain medications are prescribed.

Please sign you have read and agree : ________________________________ ***Date:*** _________________

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We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

By signing this form, I authorize the office of Dr. Charles Moniak to discuss all of my health and appointment information with the following people:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

______________________	______________________	__________
Signature	Printed Name	Date