REGISTRATION / UPDATE

Obstetrics & Gynecology

Marietta M. Tan, M.D.
Wendy Crenshaw, M.D.
Dana Edwards, M.D.
Tillaikarasi Kannappan, M.D.
Jigisha Upadhyaya, M.D.
Gregory R. Klis, M.D.
James Tsai, M.D.
Noel DelMundo, M.D.
Jacqueline Olango, M.D.
Luis Lopez, M.D.
Sonia Ghai, M.D.

Physician Assistants

Kasey Swafford, PA-C
Rosa Luna, PA-C

Nurse Practitioners

Kathleen Griffin, FNP-C
Anne Graham, FNP-C

Patient Information

Date:__________ Doctor:______________________ Primary Care Doctor: ________________________________

Full Name: ____ Previous Name Used: ________________________
Last First M.I.

Mailing Address:____ Home Phone: ________________________

City/State: ______________________________________ Zip: _______ Alternate Phone#: ____________________

Race: _________ Religion: _____________ Marital Status: S M D W

Birthdate: _____________ Age: _________ Soc. Sec. #: _________________ Driver Lic #: ________________

Email:____

If Minor: (Ask for Disclosure Information)

Parent / Guardian Name: ______________________________ Date of Birth: ______________________

Employer Information

Employer: ___________________________ Occupation: _________________________ Phone: ________

Address: ____________________________________ Hours can be reached: ________________________

If we have to contact you by phone, how shall we identify ourselves: SDMG Dr's Office Other

Best phone number to reach you: ______________________________________

Spouse Name: ________________________ Date of Birth: ________________ Soc. Sec#: ___________________

Spouse Employer: ___________________________ Work #: _____________ Occupation: __________________

Phone #: ____________________________ Alternative #: _________________ Cell #: _______________

Insurance Information

Primary Ins.: ________________________ Group/Plan#: ________________ Policy / ID# __________________

Ins. Address: ____ Eff. Date: __________________________

Policyholder's Full Name: ____ DOB: ________________
Last First M.I.

Secondary Ins.: ______________________ Group/Plan#: ________________ Policy / ID# __________________

Ins. Address: ____ Eff. Date: __________________________

Policyholder's Full Name: ____ DOB: ________________
Last First M.I.

Contact Info

In Case of Emergency, Call: ____ Relationship: _________________

Phone #: ____________________________ Alternative #: _______________________________

Financial Agreement & Release of Information

I agree to pay all fees and charges for treatment rendered on behalf of myself and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. I understand that co-payments and deductibles, which have not been satisfied, are my responsibility and are required at the time of the visit, and if I am unprepared to pay, my visit will be reappointed. I also understand that I will be charged and billed for any appointment not kept without a minimum of twenty-four hours prior notification to the office. I fully understand that if services are provided to me and/or members of my family, which are deemed to be not covered by my health plan, that I am responsible for payment in full for those services. My signature, below, constitutes agreement to the aforementioned and agreement to pay for such services.

Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. If it is necessary to assign my account to a collection agency and/or attorney to collect and unpaid balance for services previously rendered to myself or my family member, I agree to pay for all collection agency and all attorney fees and costs.

The above information is for the purposed of obtaining credit and is warranted to be true. I authorize San Dimas Medical Group, Inc., to verify employment, insurance eligibility and benefits. I authorize assignment of my insurance payment to San Dimas Medical Group, Inc. and hereby authorize my Physician to release any information acquired in the course of my examination or treatment to my insurance company as needed.

100 Old River Road
Bakersfield, California 93311
(661) 663-4800 Phone
(661) 663-4770 Fax

____ ____________________
Signature of Patient or Legal Representative Date

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New Pregnancy

Date:_______________________________ Chart #:________________________
Patient Name:_________________________ Date of Birth:____________________
Address:_____________________________ Age:____________________________
City/State/Zip:_________________________ Primary Language: _______________
Telephone Number:_____________________ OB Physician:____________________
Primary Care Physician:_________________ Chosen Pediatrician:_______________
Insurance Coverage:____
Preferred Pharmacy and Location:____

Have you been seen here for pregnancy before? Yes No

Including your current pregnancy, how many pregnancies have you had? ____________

How many live births have you had? __________________

Any miscarriages? Yes No How many?_________ What year?________

Any elective abortions? Yes No How many?_________ What year?________

Any ectopic pregnancies? Yes No How many?_________ What year?________

Any stillbirths? Yes No How many?_________ What year?________

If yes, what was the cause of the stillbirth? ______________________________

Any children born with birth defects? Yes No

If yes, please specify:____

What was the first day of your last period? ________________________

How old were you when you had your first period? __________________

How often are your periods? __________________

How many days does your period last? ____________

Are your periods: Heavy Light Regular

What were you using for birth control (please circle all that apply)?

Abstinence	Condoms	Foam	IUD – Paragard	Tubal Coils
Barrier	Contraceptive Patch	Hysterectomy	Natural Family Planning	Vaginal Ring
Bilateral Tubal	Depo Provera	Nexplanon	Rhythm	Vasectomy
Birth Control Pills	Diaphragm	IUD – Mirena	IUD – Skyla	Withdrawal

If you were taking Birth Control Pills, what brand were you taking?__________________

When did you stop using birth control?_____________________________________

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Are you allergic to any medications? Yes No

If yes, please list the medications and your reaction:

Medication	Reaction

Are you currently taking any medications? Yes No

If yes, please list the medications and their dosage:

Medication	Dose	Treatment for

When was your last pap smear? ___________________ Results were: Normal Abnormal

Pregnancy History

Day / Month / Year	Was Pregnancy		Was Delivery (please list gestation wks)		Delivering Physician	Delivery Vaginal or C-Section	Sex of Child	Birth Weight	**Complications
	Miscarriage	Elective Abortion	Full Term	Pre Term					
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No

** If you noted “Yes” to Complications, please specify year and type of event (i.e., miscarriage, ectopic, elective abortion)

____

____

Continued on next page

Medical History

Please mark any medical conditions you have been or are currently being treated for:

Condition		Condition		Condition	
Acid Reflux	☐	AIDS	☐	Anemia	☐
Asthmas	☐	Bi-Polar Disorder	☐	Cancer	☐
Cervical Dysplasia	☐	Coagulation Disorders	☐	Depression / Post-Partum Depression	☐
Diabetes	☐	Endometriosis	☐	Fibroids	☐
Headaches	☐	Heart Defects	☐	Heart Murmur	☐
Hepatitis	☐	Hypertension	☐	Hyperthyroidism	☐
Hypothyroidism	☐	Infertility	☐	Kidney Disease / Stones or Infections	☐
Lupus	☐	Seizure Disorders / Epilepsy	☐	Sickle-Cell Disease	☐
Sickle-Cell Trait	☐	Tuberculosis	☐	Uterine Anomalies	☐

Diabetic Risk Assessment

Please check if present

- ☐ Type 1 Diabetes (Insulin)
- ☐ Type 2 Diabetes (Oral Hypoglycemic)
- ☐ Type 2 Diabetes (Insulin)

****If one or more of the following risks are present, a 50gm Glucola test will be recommended by your physician

- ☐ Previous Gestational Diabetes
- ☐ Family history of diabetes (Parents, Grandparents, Siblings, Children)
- ☐ Unexplained Still Birth
- ☐ Previous births with congenital anomalies
- ☐ Previous infant birth weight greater than 8lbs, 13oz.
- ☐ Prior history or current diagnosis of Polyhydramnios
- ☐ Prior history or current diagnosis of PIH, Toxemia, or Preclamsia
- ☐ Maternal age at delivery will be 35 years or older
- ☐ Maternal weight greater than 20% BMI (see chart on the right)

BMI Chart

Height	Weight
4' 9"	127
4' 10"	131
4' 11"	134
5' 0"	138
5' 1"	142
5' 2"	146
5' 3"	151
5' 4"	157
5' 5"	162
5' 6"	167
5' 7"	172
5' 8"	176
5' 9"	181
5' 10"	186
5' 11"	191

Past Surgical History

Please list any and all of your surgeries:

Year	Type of Surgery	Reason for Surgery

Continued on next page

Social History

Do you currently use illicit drugs? Yes No If yes, please list: ______________________

Do you have a history of drug abuse? Yes No If yes, please list: ______________________

Do you drink? Yes No If yes, how often? __________ How many per day? ____________

Are you currently sexually active? Yes No

What is your marital status? Single Married Living with Partner Separated Divorced

What is your ethnicity? (please circle)

African American Hispanic Asian / Filipino American Indian (or Alaskan Native)

Native Hawaiian / Pacific Islander Unknown Other: ______________________

What is your occupation? ______________________

In your occupation, are you potentially exposed to infectious diseases or hazardous materials? Yes No

If yes, please list all materials you are potentially exposed to: (i.e. radiation, biohazards, chemicals) __________

Do you smoke? Yes No If yes, how many per day? ____________

Do you use caffeine? Yes No

Do you exercise? Yes No If yes, do you exercise (please circle) Daily Weekly Seldom

Family History

Please list family members' medical conditions (please include parents and siblings)

**Do NOT include in-laws or adopted parents or siblings.

**Be sure to list any immediate family members with any history of breast, cervical, ovarian, uterine, or colon cancer.

Relative Type (Father, Mother, Siblings)	Living / Deceased	If deceased, age at death	Illnesses / Disorders

What is your height?____________ What is your weight prior to pregnancy?____________

Genetic History

Please note any conditions that pertain to yourself or immediate family members.

Condition	Please Circle Yes or No	
Thalassemia	Yes	No
Neural Tubal Defects	Yes	No

Continued on next page

Genetic History (continued)

Downs Syndrome	Yes	No
Tay-Sachs	Yes	No
Canavan / Leukodystrophy	Yes	No
Sickle-Cell	Yes	No
Hemophilia	Yes	No
Muscular Dystrophy	Yes	No
Cystic Fibrosis	Yes	No
Huntington's Chorea	Yes	No
Mental Retardation / Autism	Yes	No
Unspecified Chromosomal Disorders	Yes	No
Maternal Metabolic Disorders	Yes	No
Unspecified Birth Defects	Yes	No

Other:____

____

Personal Infection History

Please note any conditions that pertain to you.

Diseases	Please Circle Yes or No		Years or Age of Onset
AIDS	Yes	No	__________
Chlamydia	Yes	No	__________
Gonorrhea	Yes	No	__________
Hepatitis	Yes	No	__________
HIV	Yes	No	__________
HPV (Human Papilloma Virus / Genital Warts)	Yes	No	__________
HSV (Genital Herpes or Oral Herpes)	Yes	No	__________
Syphilis	Yes	No	__________
Trichomonas	Yes	No	__________
Diptheria	Yes	No	__________
Mumps	Yes	No	__________
Pertussis (Whooping Cough)	Yes	No	__________
Polio	Yes	No	__________
Rubella (Measles)	Yes	No	__________
Tuberculosis	Yes	No	__________
Tetanus	Yes	No	__________
Varicella (Chicken Pox)	Yes	No	__________