



**Hawaii Women's Healthcare**  
Comprehensive Care in Obstetrics and Gynecology

Cheryl Lynn T. Rudy, M.D.

**Cheryl L. Leialoha, M.D.**

Erin C. Gertz, M.D.

Laura A. Spector, D.O.

Andrea Wieland, APRN

## Welcome to Hawaii Women's Healthcare

Hawaii Women's Healthcare strives to provide you with the best medical care possible. We are dedicated to caring for women in all phases of their lives. For many women, having a female physician can be comforting when dealing with sensitive women's health issues. We understand your concerns from a woman's point of view. We are strong advocates on many women's health care issues and are dedicated to improving the quality of medical care for women in our community.

- **Payment** - Payment is requested on the day of service. This will enable us to minimize the cost of billing and postage thus keeping our medical fees to a minimum. We accept cash, checks and credit cards. There is a \$10.00 billing fee if payment is not received on the day of service. Delinquent payment after 90 days will be referred to our collection agency. There is a \$25.00 collection fee if your account is referred to our collection agency. If you are having financial difficulties, please contact our office.
- **Appointments** - We have set aside time for your visit which may prevent others from being seen that day. **You may be assessed a \$25.00 no-show fee if you fail to keep your appointment or cancel within 24 hours of your scheduled time.** Please arrive for your appointment no later than 15 minutes before your appointment time for optimum patient flow. **Due to the nature of our specialty, the physician may be called out of the office for an emergency. At this time, you will have the option to reschedule your appointment or returning for a later appointment.**

### Authorization to release information and insurance payments

I request payment of authorized Medicare and/or other insurance company benefits be made to me or on my behalf to **Cheryl L. Leialoha, M.D.** for any services furnished to me by that physician. I authorize any holder of medical information about me to release it to the above insurance carriers or to the Health Care Financing Administration and its agents if required, any information needed to determine these benefits or the benefits payable for related services which may include information on sexually transmitted diseases and HIV. I understand that I am responsible for any amount not covered by my insurance.

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Signature of Patient or Legal Guardian

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Date

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Print Name of Patient or Legal Guardian



**Medical History Data Base**

Please complete all items. If is not applicable, please write N/A.

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Ethnic/Racial Background: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_

**A. PERSONAL MEDICAL HISTORY:**

- List medications you are currently taking: \_\_\_\_\_
- List any allergic/reaction you've had to any drug, medication or other substance \_\_\_\_\_
- Have you ever had or needed treatment for: Clinician's Notes:

Severe or Frequent Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
High Blood Pressure (Hypertension)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Heart Problems (murmurs/surgery)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Stroke or Stroke-like Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Elevated Blood Sugar (Diabetes)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Neurologic Problems (Epilepsy)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Liver Disease (Hepatitis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Gallbladder Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Stomach Problems (Ulcers)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Bladder Problems (Incontinence)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Bowel Problems (Colitis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Kidney Disease (UTI)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Lung Disease (TB, Asthma)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Breast Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Anemia/Sickle Cell Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Psychiatric Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____

**B. GYNECOLOGIC HISTORY:**

**Menstrual History: (if in menopause, skip to next section)**

- The first day of my last menstrual period (date): \_\_\_\_\_
- My period usually comes every \_\_\_\_\_ days (example: once a month = 28 – 30 days)
- When I have my period, it usually lasts \_\_\_\_\_ days.
- Do you have any problems related to your period?  No  Yes

If yes, please explain \_\_\_\_\_

- Do you have pain/cramps with your period?  No  Yes
- How old were you when you had your first period? \_\_\_\_\_

**Menopausal History:**

- Year menopause began (date of your last period): \_\_\_\_\_
- Any bleeding since menopause?  No  Yes
- Any problems with the following?
 

Vaginal Dryness	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hot Flashes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Urination	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bowel Movement	<input type="checkbox"/> No	<input type="checkbox"/> Yes

**General Gynecology History:**

- Are you sexually active?  No  Yes
- Do you have other symptoms or problems related to sex?  No  Yes Explain \_\_\_\_\_

Please continue questions on the back of this form →

3. Age at first intercourse? \_\_\_\_\_
4. Current method of birth control \_\_\_\_\_
5. What other methods of birth control have you used? \_\_\_\_\_
6. Have you ever had any of the following? (check all that apply)
- Trichomonas     Herpes     Condyloma (genital warts)     HIV     Herpes
- Gonorrhea     Syphilis     Bacterial Vaginitis     Chlamydia
7. Have you ever had an infection of the uterus, tubes or ovaries?  No     Yes
8. Have you ever had any of the following? (check all that apply)
- History of gynecological disease such as fibroids, endometriosis, etc. Explain \_\_\_\_\_
- Abnormal mammogram    Date \_\_\_\_\_     Abnormal pap smear    Date \_\_\_\_\_
- Colonoscopy    Date \_\_\_\_\_     Cryotherapy    Date \_\_\_\_\_
- LEEP    Date \_\_\_\_\_
9. Date of last pap smear? \_\_\_\_\_ Result \_\_\_\_\_
10. Date of last mammogram? \_\_\_\_\_ Result \_\_\_\_\_ Location \_\_\_\_\_

**C. OBSTETRICAL HISTORY:** Please list all pregnancies.

Year	Vaginal or C- Section	Miscarriage	Abortion	Boy or Girl	Problems/Complications	Hospital Name

**D. SURGERY AND HOSPITALIZATION HISTORY:**

Year	Surgery	Hospitalization	Problem(s)

**E. SOCIAL HISTORY:**

- Do you
- |                                |                             |                              |                     |                  |
|--------------------------------|-----------------------------|------------------------------|---------------------|------------------|
| Smoke                          | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Amt/Day ____        | # years use ____ |
| Drink Alcohol                  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Amt/Day ____        | # years use ____ |
| Use Illicit/Recreational Drugs | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Amt/Day ____        | # years use ____ |
| Exercise Regularly             | <input type="checkbox"/> No | <input type="checkbox"/> Yes | How often _____     |                  |
| Have a history of abuse?       | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Type of abuse _____ |                  |

**F. FAMILY MEDICAL HISTORY:**

Do any of your relatives have the following?

Medical Illness	Yes	No	Maternal (Mom's side)	Paternal (Dad's side)
Cancer				
Diabetes				
Heart Disease				
Stroke				
High Blood Pressure				
Thyroid Disease				
High Cholesterol				
Kidney Disease				
Hepatitis				
Tuberculosis				
Bleeding Disorder				
Other				

By signing below, I certify the information I have provided to Hawaii Women's Healthcare is accurate and complete to the best of my knowledge.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

- Cheryl Lynn T. Rudy, M.D.     Cheryl Leialoha, M.D.     Erin C. Gertz, M.D.     Laura A. Spector, D.O.     Andrea Wieland, APRN



## Patient Information

Patient Name (Last, First, Middle)		Date of Birth	Social Security Number	
Patient Address			City, State, Zip Code	
Primary Phone Number		Cell Phone Number	E-mail Address	
Marital Status	Are you a student? Full or Part Time?	How were you referred to us?		
Employer		Occupation	Work Number	
Person responsible for the bill		Relationship to you	Phone Number	
Billing Address			City, State, Zip Code	
Emergency Contact	Relationship to you	Phone Number	Address	
Patient's Signature			Date	

## Insurance Information

Primary Insurance Company		Policy Number	Coverage Code	Group Number
Subscriber's Name		Subscriber's Date of Birth	Subscriber's Social Security Number	Effective Date
Subscriber's Employer		Subscriber's Occupation	Subscriber's Work Number	
Insurance Mailing Address				
Secondary Insurance Company		Policy Number	Coverage Code	Group Number
Subscriber's Name		Subscriber's Date of Birth	Subscriber's Social Security Number	Effective Date
Subscriber's Employer		Subscriber's Occupation	Subscriber's Work Number	
Insurance Mailing Address				

The undersigned hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and or dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
(Patient's Name) (Name of insurance company)

to pay and hereby assign directly to **Cheryl L. Leialoha, M.D.** all benefits, if any, otherwise payable to me for services.

I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to

**Cheryl L. Leialoha, M.D.** will be credited to my account, in accordance with the above said assignment.

Subscriber's signature \_\_\_\_\_ Date \_\_\_\_\_



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### **HIPAA Patient Privacy Acknowledgement Form**

I consent to the use or disclosure of my protected health information by Cheryl L. Leialoha, M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Cheryl L. Leialoha, M.D. I understand that diagnosis or treatment of me by Cheryl L. Leialoha, M.D. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Cheryl L. Leialoha, M.D. is not required to agree to the restrictions that I may request. However, if Cheryl L. Leialoha, M.D. agrees to the restriction that I request, the restriction is binding on Cheryl L. Leialoha, M.D.

I have the right to revoke this consent, in writing, at any time, except to the extent that Cheryl L. Leialoha, M.D. has taken action in reliance on a government agency directive as outlined in the Notice of Privacy Practices.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Cheryl L. Leialoha, M.D. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Cheryl L. Leialoha, M.D. The Notice of Privacy Practices for Cheryl L. Leialoha, M.D. is provided at Hawaii Women's Healthcare. This Notice of Privacy Practices also describes my rights and Cheryl L. Leialoha, M.D. duties with respect to my protected health information.

Cheryl L. Leialoha, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Legal Representative (Parent) Date

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**Print Name of Patient** and Print Name of Legal Representative

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Description of Legal Representative's Authority