Patient Information
Obstetrics and Gynecology
Please provide us with your insurance and valid ID

PATIENT'S INFORMATION

NAME (Last, First, Middle)			PREVIOUS LAST NAME		NICKNAME
SOCIAL SECURITY NUMBER		BIRTHDATE	SEX ☐ MALE ☐ FEMALE		
DRIVER'S LICENSE NUMBER		STATE ISSUED	PLACE OF BIRTH CITY_____ STATE_____		

PATIENT'S BILLING/MAILING ADDRESS

STREET OR PO BOX		
CITY	STATE	ZIP
COUNTRY ☐ USA ☐ OTHER _____	COUNTY	

PATIENT'S PHYSICAL ADDRESS

STREET ADDRESS		
CITY	STATE	ZIP
COUNTRY ☐ USA ☐ OTHER _____	COUNTY	

PATIENT'S CONTACT INFORMATION

HOME PHONE #	DAY PHONE #	ALTERNATE PHONE	E-MAIL ADDRESS

PATIENT'S EMERGENCY CONTACT INFORMATION

NAME	ADDRESS	RELATIONSHIP	CONTACT PHONE NUMBER

PATIENT'S ADDITIONAL INFORMATION

MOTHER'S MAIDEN NAME	RACE ☐ ASIAN ☐ PACIFIC ISLANDER ☐ BLACK ☐ UNKNOWN ☐ NATIVE AMERICAN ☐ WHITE ☐ OTHER	LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER _____	RELIGION / CHURCH	
ETHNICITY ☐ HISPANIC ☐ NON-HISPANIC ☐ UNKNOWN	MARITAL STATUS ☐ ANNULLED ☐ POLYGAMOUS ☐ DIVORCED ☐ SINGLE ☐ INTERLOCUTORY ☐ WIDOWED ☐ LEGALLY SEPARATED ☐ LIFE PARTNER ☐ UNKNOWN ☐ MARRIED	STUDENT STATUS ☐ FULL-TIME ☐ NOT A STUDENT ☐ PART-TIME	VETERAN ☐ YES ☐ NO	SMOKER ☐ YES ☐ NO

REFERRING PHYSICIAN

NAME
STREET ADDRESS
CITY, STATE, AND ZIP
OFFICE PHONE NUMBER
FAX NUMBER

PRIMARY CARE PROVIDER/PHYSICIAN

NAME
STREET ADDRESS
CITY, STATE, AND ZIP
OFFICE PHONE NUMBER
FAX NUMBER

RESPONSIBLE PARTY'S INFORMATION (if different than above)

NAME (Last, First, Middle)			PREVIOUS LAST NAME		NICKNAME
SSN	BIRTHDATE	SEX	RELATIONSHIP TO PATIENT		

RESPONSIBLE PARTY'S BILLING/MAILING ADDRESS

STREET OR PO BOX		
CITY	STATE	ZIP
HOME PHONE NUMBER		

RESPONISBLE PARTY'PHYSICAL ADDRESS

STREET ADDRESS		
CITY	STATE	ZIP
E-MAIL ADDRESS		

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PATIENT'S EMPLOYER

NAME OF EMPLOYER	☐ LOCAL ADDRESS ☐ CORPORATE ADDRESS
EMPLOYER'S ADDRESS (Street, City, State and Zip)	COUNTY
TYPE OF BUSINESS	OCCUPATION
EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ DISABLED	WORK PHONE

PRIMARY INSURANCE

NAME OF SUBSCRIBER (Last, First, Middle)	RELATIONSHIP TO PATIENT	
SUBSCRIBER'S ADDRESS (Street, City, State and Zip)	POLICY NUMBER	
SUBSCRIBER'S SOCIAL SECURITY NUMBER	SUBSCRIBER'S DATE OF BIRTH	
NAME OF INSURANCE COMPANY	GROUP NUMBER	
ADDRESS OF INSURANCE COMPANY (Street, City, State, and Zip)	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if applicable)

NAME OF SUBSCRIBER (Last, First, Middle)	RELATIONSHIP TO PATIENT	
SUBSCRIBER'S ADDRESS (Street, City, State and Zip)	POLICY NUMBER	
SUBSCRIBER'S SOCIAL SECURITY NUMBER	SUBSCRIBER'S DATE OF BIRTH	
NAME OF INSURANCE COMPANY	GROUP NUMBER	
ADDRESS OF INSURANCE COMPANY (Street, City, State, and Zip)	EFFECTIVE DATE	EXPIRATION DATE

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____ and assign directly to Dr. _____ all medical benefits. **I understand that I am financially responsible for all charges incurred. A copy of the back and front of my insurance card is required for billing purposes.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. Sometimes healthcare information may be used for research, all such information is anonymous, and patient confidentiality is maintained. If you do not want any information to be used for research please check here _____.

Signature of Insured _____ **Date** _____

CONSENT FOR TREATMENT

I, the undersigned hereby authorize and give consent to Dr. _____ for any x-rays examinations, laboratory tests, and treatment rendered to the patient named above.

Signature _____ **Date** _____

MEDICARE AUTHORIZATION

I request the payment of authorized Medicare benefits be made directly to me or the physician rendering services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Signature _____ **Date** _____

Please be advised, it is the patient's responsibility to ensure that the physician they see is contracted with their insurance plan.

REV. 08262013

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PATIENT'S INFORMATION	
NAME (Last, First, Middle)	BIRTHDATE
PREFERRED PHARMACY (Name, Address, Phone Number)	BACK UP PHARMACY (Name, Address, Phone Number)

REASON FOR VISIT	
Patients Injury/Illness: 1. 2. 3.	Onset Date: _____ Rate of Pain(0= no pain; 10= most severe) 1 2 3 4 5 6 7 8 9 10

ALLERGIES (Medication(s), Environmental Issue(s), and Food(s))	
Item(s) that you are *allergic* to:	Reaction(s) you have had from the *Allergen,* you are allergic to:

MEDICATIONS AND SUPPLEMENTS THAT YOU TAKE ON REGULAR BASIS			
Drug Name (Brand name, or generic name)	Dosage	Times taken within 24 Hours	Reason for taking Medication

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PATIENT INFORMATION

NAME (Last, First, Middle)	BIRTHDATE

REVIEW OF SYSTEMS

CONSTITUTIONAL:

No	Yes		No	Yes	
□	□	Chills	□	□	Weight Gain
□	□	Fatigue	□	□	Weight Loss
□	□	Fever			
□	□	Malaise			
□	□	Night Sweats			
□	□	Weakness			

METABOLIC/ENDOCRINE:

No	Yes	
□	□	Cold Intolerance
□	□	Heat Intolerant
□	□	Polydipsia
□	□	Polyphagia

GENITOURINARY:

No	Yes	
□	□	Dysuria
□	□	Hematuria
□	□	Polydipsia
□	□	Urinary frequency
□	□	Urinary incontinence
□	□	Urinary retention

HEAD, EYES, EARS, NOSE, AND THROAT:

No	Yes	
□	□	Ear drainage
□	□	Ear pain
□	□	Eye discharge
□	□	Eye pain
□	□	Hearing loss
□	□	Nasal drainage
□	□	Sinus pressure
□	□	Sore throat
□	□	Eye Redness

NEUROLOGICAL:

No	Yes	
□	□	Dizziness
□	□	Extremity numbness
□	□	Extremity weakness
□	□	Gait disturbance
□	□	Headache
□	□	Memory loss
□	□	Seizures
□	□	Falls

REPRODUTIVE:

No	Yes	
□	□	Abnormal Pap
□	□	Dysmenorrhea
□	□	Dyspareunia
□	□	Hot flashes
□	□	Irregular menses
□	□	Discharge

RESPIRATORY:

No	Yes	
□	□	Chronic cough
□	□	Cough
□	□	Known TB exposure
□	□	Shortness of breath
□	□	Wheezing

PSYCHIATRIC:

No	Yes	
□	□	Anxiety
□	□	Depression
□	□	Insomnia

Musculoskeletal:

No	Yes	
□	□	Back pain
□	□	Joint pain
□	□	Joint swelling
□	□	Muscle weakness
□	□	Neck pain

CARDIOVASCULAR:

No	Yes	
□	□	Chest Pain
□	□	Claudication
□	□	Edema
□	□	Palpitations

INTEGUMENTARY (SKIN):

No	Yes	
□	□	Brittle hair
□	□	Brittle nails
□	□	Rash
□	□	Hives
□	□	Skin Lesion
□	□	Pruritus

IMMUNOLOGIC

No	Yes	
□	□	Contact allergy
□	□	Environmental allergies
□	□	Food allergies
□	□	Seasonal allergies

GASTROINTESTINAL:

No	Yes	
□	□	Abdominal Pain
□	□	Blood in stools
□	□	Change in stools
□	□	Constipation
□	□	Diarrhea
□	□	Heartburn
□	□	Loss of appetite
□	□	Nausea
□	□	Vomiting

HEMATOLOGIC:

No	Yes	
□	□	Easy bleeding
□	□	Easy bruising
□	□	Lymphadenopathy

OTHER CONDITIONS NOT NOTED:

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CHRONIC PROBLEM LIST

Chronic Problem	Onset Date

PAST MEDICAL/SURGICAL HISTORY

Procedure	Year	

FAMILY HISTORY (Please List only Mother, Father, Brother, and Sister)

□ PATIENT ADOPTED □ NO RELEVANT FAMILY HISTORY

Diagnosis	Family Member	Name	Age Onset or Age Death	Comments

SOCIAL HISTORY

Uses Tobacco: □ Currently □ Formerly □ Never □ Unknown

Type: □ Chewing □ Cigar □ Cigarettes □ Pipe □ Smokeless □ Snuff

Recreational Drug Use: □ Currently □ Formerly □ Never □Unknown

□ Marijuana □ IV □ Other_____

Units/Day: _____

Years Used: _____

Occupation: _____

Marital Status: _____

Number of Children: _____
□ Vaginal How Many: _____
□ C-Section How Many: _____

Alcohol Use:
□ Yes □ No
□ Formerly - Year Quit _____

If "YES" –
Type of Alcohol _____

Frequency _____

When was Last Drink _____

Caffeine Use:
□ Yes □ No

Type _____

Amount Daily _____

WHEN WAS YOUR LAST:

Immunizations:

Pneumonia _____
Tostavax _____
Flu Vaccine _____
Tdap _____
TB Skin Test/PPD _____
HPV – Human Papilloma Virus-Gardasil _____

Diagnostic Procedures:

Mammogram _____ Eye Exam _____
DXA _____ IVP _____
PAP Smear _____ EKG _____
Stool Blood Test _____ MRI Scan _____
Colonoscopy _____ CT Scan _____
EGD _____ Pulmonary Function Test _____
PSA _____ Aortic Ultrasound _____
Chest Xray _____ Gallbladder Sonogram _____
ECHO _____ Angiogram/Cath _____
Curated Duplex/Ultrasound _____ Treadmill _____

_____ _____ _____
Patient's Printed Name Patient's Signature Date Signed