

**PATIENT INFORMATION**

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Marital Status:      Single      Married      Separated      Divorced      Widow/Widower  
(Please circle one)

Sex:    Male/Female  
(Please circle one)

Employed:    Yes/No  
(Please circle one)

Employer's Name and Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

**BILLING INFORMATION**

Person responsible for paying bill:      Patient      Parent      Spouse      Other: \_\_\_\_\_  
(Please circle one)

Name (if different from above): \_\_\_\_\_ DOB: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Telephone: \_\_\_\_\_ Work: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer's Name and Address: \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance**

Insurance Company Name      Address, City, State, Zip Code, Telephone Number

Subscriber's ID      Group Number      Policyholder's Name      Social Security Number

Patient's relationship to policyholder (please circle one):    Self    Spouse    Child    Other    DOB policyholder: \_\_\_\_\_

**Secondary Insurance**

Insurance Company Name      Address, City, State, Zip Code, Telephone Number

Subscriber's ID      Group Number      Policyholder's Name      Social Security Number

Patient's relationship to policyholder (please circle one):    Self    Spouse    Child    Other    DOB policyholder: \_\_\_\_\_

**Person to Contact in Case of Emergency**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**PLEASE COMPLETE ALL INFORMATION ON THE REVERSE SIDE**

## FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

### FINANCIAL AGREEMENT

Initial

\_\_\_\_\_ I have no insurance coverage; I understand that I am responsible for payment of services rendered to myself or dependents at the time of service.

\_\_\_\_\_ I understand if I fail to pay amounts owed; the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

### INSURANCE AUTHORIZATION AND ASSIGNMENT

Initial

\_\_\_\_\_ I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

### MEDICARE/MEDIGAP

#### FOR MEDICARE PATIENTS ONLY

\_\_\_\_\_ Medicare Number

\_\_\_\_\_ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S. C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

#### MEDIGAP AUTHORIZATION STATEMENT

\_\_\_\_\_ Policy Number

\_\_\_\_\_ I authorize any holder of medical or other information about me to be released to process this Medigap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts the assignment.

**THERE WILL BE A \$25.00 CHARGE ON ALL RETURNED CHECKS.**

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY.

\_\_\_\_\_  
Patient/Parent/Guardian

\_\_\_\_\_  
Date

PLEASE PRESENT BOTH YOUR INSURANCE CARD AND YOUR DRIVER'S LICENSE SO WE MAY MAKE A COPY FOR OUR RECORDS.

## INITIAL GYN MEDICAL HISTORY

PATIENT'S NAME \_\_\_\_\_ DATE \_\_\_\_\_  
DOB / / \_\_\_\_\_ Martial Status: S M D W (Circle) Phone: \_\_\_\_\_  
Educational level: \_\_\_\_\_ Religion \_\_\_\_\_ Sexual preference: \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Who referred you here: \_\_\_\_\_

**OCCUPATION HISTORY** Occupation: \_\_\_\_\_ Place of employment: \_\_\_\_\_  
Work number: \_\_\_\_\_ Cell # \_\_\_\_\_  
**If not working are you:** Unemployed Retired disabled student

**REASON FOR VISIT:**

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**MENSTRUAL HISTORY**

Age of onset of periods \_\_\_\_\_ If stopped periods, age \_\_\_\_\_  
Date of Last period: / / \_\_\_\_\_ Age of first sexual activity: \_\_\_\_\_  
How frequent are periods? \_\_\_\_\_ Method of Birth Control \_\_\_\_\_  
Do you need a method of birth control today? Yes NO Kind wanted? \_\_\_\_\_  
Any hx of abnormal paps \_\_\_\_\_ Any hx of sexually transmitted Diseases \_\_\_\_\_  
Do you have any of the following problems with period now? Heavy periods Irregular periods  
painful periods spotting between periods vaginal discharge pelvic pain decreased  
libido  
Last mammogram: \_\_\_\_\_ Last pap smear \_\_\_\_\_ Bone Density \_\_\_\_\_  
Any abnormal vaginal discharge now? Yes No Any vulvar itching now? Yes NO

**PREGNANCY HISTORY**

Number of pregnancies \_\_\_\_\_ / Number of deliveries \_\_\_\_\_ number of miscarriages \_\_\_\_\_ abortions \_\_\_\_\_  
Number of stillborns \_\_\_\_\_ C Section# \_\_\_\_\_ Vaginal deliveries# \_\_\_\_\_

**SURGERIES**

Have you had any surgery? Explain: 1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

**Do You Take Any Medications, if yes (Name Prescription. and Non-Pres. meds):**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_  
7. \_\_\_\_\_ 8. \_\_\_\_\_ 9. \_\_\_\_\_

**Are you allergic to any medication?** Yes No If yes, what \_\_\_\_\_

**Have you been diagnosed with any medical problems? If yes, please list:**

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_

(Please complete all information on reverse side)

(continue)

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

**Medical symptoms/recent history of**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> hot flashes/night sweats | <input type="checkbox"/> anemia             | <input type="checkbox"/> breast problems    | <input type="checkbox"/> hx blood clots in legs   |
| <input type="checkbox"/> bladder problems         | <input type="checkbox"/> urination problems | <input type="checkbox"/> bladder leakage    | <input type="checkbox"/> hepatitis/liver problems |
| <input type="checkbox"/> sudden wt. loss          | <input type="checkbox"/> liver disease      | <input type="checkbox"/> Stomach problems   | <input type="checkbox"/> hemorrhoids              |
| <input type="checkbox"/> constipation             | <input type="checkbox"/> blood in stool     | <input type="checkbox"/> GB problems        | <input type="checkbox"/> Skin disease/lesions     |
| <input type="checkbox"/> lung problems            | <input type="checkbox"/> breathing problems | <input type="checkbox"/> pulmonary embolus  | <input type="checkbox"/> stroke/embolus           |
| <input type="checkbox"/> headaches                | <input type="checkbox"/> depressed          | <input type="checkbox"/> anxious            | <input type="checkbox"/> thyroid problems         |
| <input type="checkbox"/> heart problems           | <input type="checkbox"/> chest pain         | <input type="checkbox"/> blood transfusions | <input type="checkbox"/> hypertension             |
| <input type="checkbox"/> skin diseases            | <input type="checkbox"/> heart murmur       | <input type="checkbox"/> skin changes       | <input type="checkbox"/> seizures                 |
- cancer, if yes please explain: \_\_\_\_\_
- fractures, kind \_\_\_\_\_
- back problems \_\_\_\_\_
- diabetes \_\_\_\_\_
- sexual abuse \_\_\_\_\_
- polycystic ovaries \_\_\_\_\_
- changing moles \_\_\_\_\_
- physical/emotional abuse \_\_\_\_\_
- TB history \_\_\_\_\_
- fibrocystic breast \_\_\_\_\_

Any others not mentioned, please explain: \_\_\_\_\_

**FAMILY HISTORY Please complete as much as possible! This information is very helpful!**

- Father:** Age \_\_\_\_\_ Deceased \_\_\_\_\_ Health Problems/Cause of Death \_\_\_\_\_
- Mother:** Age \_\_\_\_\_ Deceased \_\_\_\_\_ Health Problems/Cause of Death \_\_\_\_\_
- Brothers:** How many \_\_\_\_\_ Living \_\_\_\_\_ Deceased \_\_\_\_\_ Health Problems \_\_\_\_\_
- Sisters:** How Many \_\_\_\_\_ Living \_\_\_\_\_ Deceased \_\_\_\_\_ Health Problems \_\_\_\_\_
- Maternal GF:** Living \_\_\_\_\_ Deceased \_\_\_\_\_ Health problems: \_\_\_\_\_
- Maternal GM** Living \_\_\_\_\_ Deceased \_\_\_\_\_ Health problems: \_\_\_\_\_
- Paternal GF** Living \_\_\_\_\_ Deceased \_\_\_\_\_ Health problems: \_\_\_\_\_
- Paternal GM** Living \_\_\_\_\_ Deceased \_\_\_\_\_ Health problems: \_\_\_\_\_

**ANY FAMILY HISTORY OF OTHER BLOOD RELATIVES WITH:**  Diabetes  Cancer If yes, what kind \_\_\_\_\_

High Blood Pressure  Stroke  Mental Illness  TB  Obesity  Arthritis, Kind \_\_\_\_\_

Suicide  Abuse (alcohol/drugs)  Heart problems  Thyroid problems  Coronary Artery Disease  Other Genetic diseases: \_\_\_\_\_

**OTHER PERSONAL HISTORY:**

- Do you Exercise regularly? \_\_\_\_\_
- Do you take calcium with Vit D? if yes how much \_\_\_\_\_
- Do you smoke \_\_\_\_\_ how much: \_\_\_\_\_ Age started \_\_\_\_\_
- Do you use any illegal drugs? \_\_\_\_\_ What \_\_\_\_\_
- Do you drink alcohol? \_\_\_\_\_ How often/much? \_\_\_\_\_
- Do you feel you are in any kind of danger in your home?  YES  NO

**IMMUNIZATIONS:** Last tetanus \_\_\_\_\_ Hepatitis A \_\_\_\_\_ B \_\_\_\_\_

Do you take a yearly flu shot?  Yes  No Pneumonia shot  Yes  No

Meningitis  Yes  No HINI  Yes  No

Have you had the Gardasil series for HPV prevention?  Yes  No

If No, are you interested in getting it?  Yes  No

**OTHER**

**COMMENTS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_