

PATIENT INFORMATION

CONFIDENTIAL

File #: _____

(Please Print)

Date: _____

Name: _____
Last MI First

Home Phone #: _____

Birthdate: _____ Social Security Number: _____ Cell Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Circle Appropriate Status: Minor Single Married Divorced Widowed Separated

Patient's Employer: _____ Work Phone: _____ Ext: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse Or Parent's Name: _____ Employer: _____ Work Phone: _____ Ext: _____

Whom May We Thank For Referring You? _____

Person To Contact In Case Of An Emergency: _____ Phone: _____

E-Mail Address: _____

May We Send Normal Test Results And Other Information To This E-Mail Address? _____

Signature

INSURANCE INFORMATION

Name Of Insured: _____ Relationship To Patient: _____

Birthdate: _____ Social Security Number: _____ Date Employed: _____

Name Of Employer: _____ Work Phone: _____

Address Of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ ID #: _____ Group #: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Effective Date Of Insurance Policy: _____

Does Your Insurance Require A Referral From Your Primary Care Physician? Yes No

Do You Have Any Additional Insurance?

Yes No

If Yes Complete The Following

Name Of Insured: _____ Relationship To Patient: _____

Birthdate: _____ Social Security Number: _____ Date Employed: _____

Name Of Employer: _____ Work Phone: _____

Address Of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ ID #: _____ Group #: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Effective Date Of Insurance Policy: _____

SIGNATURE ON FILE

In order to bill your insurance company for services rendered we need your signature on file.

- I authorize the use of this form on all my insurance submissions
- I authorize release of information to my insurance carrier
- I understand that I am responsible for my bill
- I release this office from all liabilities incurred due to non-reimbursed referrals
- I authorize the doctor to act as my agent to obtain payment
- I authorize payment directly to my doctor
- I permit a copy of this authorization to be used in place of the original

Signature: _____

Patient's Name: _____ Age: _____ Birth Date: _____ Date of Exam: _____
 Primary Care Physician: _____ Last PAP: _____ Last Annual: _____ Last Mammogram: _____

Reason for appointment: _____

Menstrual History

First day of last menstrual period: _____ Age at first period: _____ Are your periods regular? Yes No
 How many days between period? _____ How many days does your period last? _____
 If not getting periods, what age were you when your period stopped? _____

Comments: _____

Obstetrical History

Number of Pregnancies _____ Births _____ Miscarriages _____ Abortions _____
 Vaginal births _____ Cesarean births _____ Vaginal births after Cesarean births _____

Comments: _____

Are you sexually active? Yes No

Current forms of birth control: **NONE**

If any, please specify: _____

Past Medical & Family History

	Self	Fam		Self	Fam	Comments
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you had (please check all that apply): **NONE**

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> STD Exposure |
| <input type="checkbox"/> Changes in periods | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> STD Screening (i.e. HIV, Hepatitis B, C, Syphilis, Gonorrhea, Chlamydia) |
| <input type="checkbox"/> Severe pain with periods | <input type="checkbox"/> Depression | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> Changes in your breasts | <input type="checkbox"/> Experienced sexual abuse | _____ |
| <input type="checkbox"/> Abnormal vaginal discharge | <input type="checkbox"/> Changes in bowel habit | _____ |
| <input type="checkbox"/> Vaginal burning or itching | <input type="checkbox"/> Recent weight change | _____ |

Comments: _____

Surgeries or Hospitalizations: **NONE**

Type of Surgery or Reason for Hospitalization (Please include dates)

1. _____
2. _____
3. _____

List any drug/food allergies: **NONE** If yes, please specify: _____

Medications – Please list **all** current medications (including prescriptions, hormone replacement, vitamins, calcium, and over-the-counter medications)

NONE

Medications:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |