OBSTETRICS & GYNECOLOGY, CARE LLC

Status: Doctor: Today's Date:

Chart #: Account #:

PATIENT INFORMATION

Patient Name: First, Middle Initial, Last			Maiden Name	Nick Name
Home address including city, state & zip:				
Date of Birth	Age	Social Security Number		Marital Status
Home Phone	Cell Phone	Work Phone		Email Address
Employed/School		Occupation:		
Name or person responsbile for payment			Relationship:	Home Phone:
Address include city, state and zip:				
Emergency Contact:			Relationship:	Contact Phone Number:

SPOUSE/PARENT INFO

Relationship	Name:	Soc. Sec. No.
Address include city, state & zip:		Home phone
Employed By:		
Date of Birth:	Work Phone:	Cell Phone:

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Primary Insurance:	Copay	Group #	Policy #	Effective Date
Policy Holder's Name:	Address include City, State & Zip:			Phone # of Insured Party
Policy Holder's Soc. Sec #	Sex of Policyholder	Date of Birth:	Insured Party Relationship-self, parent, spouse, child, other	

SECONDARY INSURANCE INFORMATION

Secondary Insurance:	Copay	Group #:	Policy #	Effective Date
Policy Holder's Name:	Address include City, State & Zip			Phone # of Insured Party
Policy Holder's Soc. Sec #	Sex of Policyholder:	Date of Birth:	Insured Party Relationship-self, parent, spouse, child, other	

Guarantor's Signature Date

PRIVACY PRACTICE/CONFIDENTIALITY DISCLOSURE

Date:_____ Patient Name: _____

I acknowledge that I have received a copy of Obstetrics & Gynecology Care 'Notice of Privacy Practices'.

For purposes of patient care, I wish to be contacted at the following number(s):

(____) ____-_____ or (____) ____-_____

RESTRICTIONS ON THE DISCLOSURE OF MEDICAL INFORMATION

_____ You may leave a detailed message (including billing, test results, medical information).
_____ You may leave a message with no details except a call back number and 'OBGYN Care' identified.
_____ You may NOT leave a message.

Messages may be left at this number(s):

(____) ____-_____ or (____) ____-_____

RELEASE OF MEDICAL INFORMATION

I authorize OBGYN Care, LLC to use or disclose certain medical and/or billing information to (example Spouse, Family Member, etc.):

_____
Contact Person Relationship

_____
Contact Person Relationship

_____
Contact Person Relationship

ASSIGNMENT OF BENEFITS/PATIENT FINANCIAL AGREEMENT

I agree to pay for any and all medical services I receive from the providers of this practice whether or not paid by the insurance company. Some insurance companies will not pay your bill or will pay a reduced amount based on your selection of a participating/non-participating doctor. It is the patient's responsibility to determine if our doctor participates in your plan. I also understand that office co-pays are due at time of service when applicable. This office will file a claim to my insurance on my behalf. Obstetrics & Gynecology Care, LLC does not deny benefits or services because of or based on race, color, age, gender, disability, religious, or political beliefs. Any balances due by me for whatever reason will be paid promptly upon my receipt of a statement. Failure to pay within 30 days as for the purpose of this agreement, is a refusal to pay. Therefore, I agree to pay any additional costs of collection (including but not limited to collection agency fees, reasonable attorney fees and court costs), in the event that I would fail to pay my bill. A finance charge will be applied to accounts 30 days past due at 1.5% per month with an Annual Percentage Rate (APR) of 18%.

Signature:_____ Date:_____

Printed Name:_____ DOB:_____

Name _____ Gender _____ Age _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

_____
_____
_____
_____
_____
_____
_____

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

_____
_____
_____

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following:

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism ☐ Allergies ☐ Anemia ☐ Anxiety Disorder ☐ Arthritis ☐ Asthma ☐ AIDS/HIV
☐ Back Problems ☐ Bleeding Disorder ☐ Blood Disease ☐ Blood Transfusion ☐ Cancer ☐ Diabetes ☐ Depression
☐ Ear Problems ☐ Eating Disorder ☐ Epilepsy ☐ Glaucoma ☐ Gout ☐ Heart Disease ☐ Heart Problems
☐ Hepatitis-A, B, or C ☐ High Blood Pressure ☐ High Cholesterol ☐ Joint Disorder ☐ Kidney Disorder ☐ Liver Disorder ☐ Lung Disease
☐ Measles ☐ Migraines ☐ Osteoporosis ☐ Pneumonia ☐ Polio ☐ Rheumatic Fever ☐ Stroke
☐ Skin Disorder ☐ Stomach Ulcer ☐ Substance Abuse ☐ Thyroid Disorder ☐ Tuberculosis ☐ Venereal Disease

Hospitalizations & Surgeries

Reason	Date

Lifestyle Factors

Are you sexually active?
☐ Yes ☐ No # of partners in the past year _____

Do you wish to be checked for STD's?
☐ Yes ☐ No

Has anyone in your home ever physically / verbally hurt you?
☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No
# of packs _____ # packs/day _____

Do you smoke now? ☐ Yes ☐ No
packs/day _____

Do you use recreational drugs? ☐ Yes ☐ No
Types? _____ # Times/week _____

How much alcohol do you drink per week?
drinks/week _____

How much caffine do you drink per day?
drinks/day _____

How often do you exercise?
times/week _____

Family History

Has anyone in your family ever had any of the following conditions?

☐Alcoholism ☐Allergies ☐Alzheimer's ☐Anemia ☐Anxiety ☐Arthritis ☐Asthma ☐AIDS/HIV ☐Bleeding Disorder ☐Blood Disorder
☐Cancer ☐Depression ☐Diabetes ☐Epilepsy ☐Genetic Disorder ☐Glaucoma ☐Heart Disease ☐Hepatitis ☐High Cholesterol ☐High Blood Pressure
☐Joint Disorder ☐Kidney Disease ☐Liver Disorder ☐Lung Disease ☐Migraines ☐Psychiatric Disorders ☐Osteoporosis ☐Stroke ☐Substance Abuse ☐Thyroid Disorder

Details:

_____
_____
_____

Name _____ Gender _____ Age _____ Date of Appointment: _____

OB/GYN History

Have you ever had or do you currently have any of the following?

☐Abnormal Vaginal Bleeding	☐Chlamydia	☐Gonorrhea	☐Ovarian Cysts
☐Abnormal Pap Smear	☐Colposcopy	☐Herpes	☐ Ovarian Cancer
☐Bleeding Between Periods	☐Cryosurgery	☐Hot Flashes	☐Painful Intercourse
☐Breast Lump	☐DES Exposure	☐HPV	☐Pelvic Inflammatory Disease
☐Breast Cancer	☐Extreme Menstrual Pain	☐Infertility	☐Uterine Cancer
☐Breast Surgery	☐Fibroids	☐Irregular Periods/Bleeding	☐Urinary Incontinence
☐Cervical Cancer	☐Genital Warts	☐Nipple Dischage	☐Yeast Infections-Frequent

Pregnancy History

Please describe any pregnancies you have had:

_____ # of Pregnancies _____ # of Full Term _____ # of Miscarriages _____ # of Abortions

Were there any complications associated with any of your pregnancies?

_____

_____

_____

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living
_____	_____	_____	___	___
_____	_____	_____	___	___
_____	_____	_____	___	___
_____	_____	_____	___	___

Are you currently pregnant? ☐ Yes ☐ No

Are you trying to become pregnant? ☐ Yes ☐ No

Do you need birth control or contraceptive advice?
☐ Yes ☐ No

What method of birth control do you use?

_____

Menstrual History

When was the last day of your last period?

_____

How often does your period occur?

_____

How long does your period last?

_____

Is your period regular?

☐ Yes ☐ No

_____

What age were you when you had your first period?

_____

What age were you at menopause?

_____

Health Exams & Procedures

Please check and date any immunizations/procedures you have had.

	Month & Year	Results
☐ Blood Sugar Fasting	_____	_____
☐ Breast Self Exam	_____	_____
☐ Cholesterol Test	_____	_____
☐ Colonoscopy	_____	_____
☐ CT/CAT Scan	_____	_____
☐ Dexascan (Bone Density)	_____	_____
☐ EKG	_____	_____
☐ Echocardiogram	_____	_____
☐ Fecal Occult Blood Test	_____	_____
☐ Mammogram	_____	_____
☐ MRI	_____	_____
☐ Pap Smear	_____	_____
☐ Physical Exam	_____	_____
☐ Cardiac Stress Test	_____	_____
☐ Ultrasound	_____	_____

Name _____ Gender _____ Age _____ Date of Appointment: _____

Review of Systems

General

- ☐Chills
- ☐Dizziness
- ☐Fainting
- ☐Fever
- ☐Hair Loss
- ☐Hair Growth - Excessive
- ☐Night Sweats
- ☐Sleeping Problems
- ☐Thirst - Excessive
- ☐Weight Gain
- ☐Weight Loss

Mental Health

- ☐Anxiety
- ☐Depression
- ☐Loss of Interest
- ☐Feeling Hopeless
- ☐Hearing Voices
- ☐Marital Problems
- ☐Panic Attacks
- ☐Trouble Concentrating
- ☐Suicide - Thoughts/Attempts

Musculoskeletal

- ☐Back Pain
- ☐Carpal Tunnel Syndrome
- ☐Joint Pain
- ☐Joint Swelling
- ☐Neck Pain
- ☐Shoulder Pain

Gastrointestinal

- ☐Appetite Gain
- ☐Appetite Loss
- ☐Bloating
- ☐Bowel Changes
- ☐Constipation
- ☐Diarrhea
- ☐Gas
- ☐Hemorrhoids
- ☐Indigestion
- ☐Intestinal Disorder
- ☐Lactose Intolerance
- ☐Nausea
- ☐Rectal Bleeding
- ☐Stomach Pain
- ☐Vomiting
- ☐Vomiting Blood

Genitourinary

- ☐Blood in Urine
- ☐Lack of Bladder Control
- ☐Frequent Urination
- ☐Painful Urination

Respiratory

- ☐Coughing
- ☐Coughing Up Blood
- ☐Shortness of Breath
- ☐Wheezing

ENT

- ☐Bleeding Gums
- ☐Blurred Vision
- ☐Crossed Eyes
- ☐Difficulty Swallowing
- ☐Double Vision
- ☐Earaches
- ☐Ear Discharge
- ☐Hay Fever
- ☐Hoarseness
- ☐Hearing Loss
- ☐Nose Bleeds
- ☐Persistent Cough
- ☐Persistent Runny Nose
- ☐Recurring Sore Throat
- ☐Ringing in Ears
- ☐Sinus Problems
- ☐Vision Halos

Cardiovascular

- ☐Chest Pains
- ☐Irregular Heart Beat
- ☐Circulation Problems
- ☐Heart Palpitations
- ☐Rapid Heartbeat
- ☐Swelling of Ankles
- ☐Varicose Veins

Skin

- ☐Acne
- ☐Bruise Easily
- ☐Changes in Moles
- ☐Chills
- ☐Dry / Sensitive Skin
- ☐Eczema
- ☐Hives
- ☐Itching
- ☐Rash
- ☐Scars
- ☐Sores That Won't Heal

Neurological

- ☐Coordination Problems
- ☐Convulsions
- ☐Difficulty Walking
- ☐Learning Disabilities
- ☐Light Headedness
- ☐Memory Loss
- ☐Numbness / Tingling
- ☐Paralysis
- ☐Seizures
- ☐Speech Problems
- ☐Tremors

Other Symptoms

_____

_____

_____

_____

Immunizations

Please check and date all immunizations you have had.

	Month & Year		Month & Year
☐Hepatitis A	_____	☐MMR (Measles/Mumps/Rubella)	_____
☐Hepatitis B (Series of 3)	_____	☐Pneumonia	_____
☐HPV Vaccine	_____	☐Polio	_____
☐Influenza (Flu Shot)	_____	☐Tetanus	_____
☐Meningitis	_____		