OB GYN
PHYSICIANS, P.C.

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Welcome! Please print as neatly as you can and fill out all fields below when applicable.

Name: ______________________________ **DOB:** ______________
Last First MI

Marital Status (circle one): Single Married Widowed Divorced

Address: ______________________________
Street/Unit City State, Zip Code

Phone Number(s): ______________________________
****Please circle the numbers we may leave a brief message on****

Email Address: ______________ **Place of Employment:** ______________

Emergency Contact Name: ______________ **Relation to Patient:** ______________

Emergency Contact Number: ______________ **Emergency Contact DOB:** ______________

Primary Care Physician: ______________ **Phone Number:** ______________

Pharmacy Name: ______________ **Address:** ______________

All copays are due at check in.
If you do not have insurance and are a self pay patient your balance is due at check in.

Primary Insurance: ______________ **ID:** ______________

Primary Cardholder: ______________ **DOB:** ______________

Relationship to Patient: ______________ **Policy Effective Date:** ______________

Secondary Insurance: ______________ **ID:** ______________

Primary Cardholder: ______________ **DOB:** ______________

Relationship to Patient: ______________ **Policy Effective Date:** ______________

Patient Signature: ______________________________

Date: ______________

Patient Questionnaire

Name: ______

Reason for Visit: ______

Medications (dosage/frequency) ______

Allergies: ______

Date of Last Pap: ______ ☐ Normal ☐ Abnormal

Date of Last Mammogram: ______ ☐ Normal ☐ Abnormal

Past Medical & Family History

Please (✓) if you or any blood relative had any of the following conditions

	Self	Family		Self	Family
1. Wt. Loss-Gain			16. Urinary Incontinence		
2. Headaches/Migranes			17. Urinary Infections		
3. Heart Disease			18. Blood Transfusion		
4. Valvular Disease			19. Anemia/Blood Disorder		
5. Rheumatic Disease			20. Varicose Veins/ Phlebitis		
6. High Blood Pressure			21. Skin Disease		
7. High Cholesterol			22. Diabetes		
8. Respitory Diease			23. Thyroid Disease		
9. Pulmonary (Lung) Disease			24. Cancer		
10. Breast Disease			Type:		
11. Jaundice/Hepatitis			25. Epilepsy/ Neurological Disease		
12. Hiatal Hernia (Reflux)			26. Arthritis (Joint Pain)		
13. Peptic Ulcer (stomach)			27. Osteoporosis (Fragile Bones)		
14. Bowel Disease			28. Anxiety/Depression		
15. Kidney Disease			29. Sleep Problems		

Hospital Admissions: Any operations & serious illnesses (excluding pregnancy)

Year:			
Reason:			

Menstral History

Age at first period:

First day of last period:

Duration of bleeding:

Cramps ☐ Yes ☐ No

Contraceptive History

Current Method:

Brand:

Past Method:

Menopausal History

Hot Flashes ☐ Yes ☐ No

Treatment:

Obstetrical History

Number of Pregnancies:

Premature Babies

Miscarriages:

Abortions:

Living children:

Year	WT	Sex

Weeks Pregnant:

Type of Delivery:

Year	WT	Sex

Weeks Pregnant:

Type of Delivery:

History of Vaginal Infection

Yes	No	
		Yeast
		Trichomonas
		Chlamydia
		Herpes
		Gonorrhea
		Bacterial Vaginosis

Sexual History

☐ Satisfactory

☐ Uncomfortable

☐ Wish to discuss

Social History

Smoking per day/year ☐ ☐ ☐

Alcohol # per Week ☐ ☐

Coffee Cups per Day ☐ ☐

Street Drugs ☐

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Financial Policy

1. I understand that any services rendered to me are solely my financial responsibility.

2. I understand that if I do not have insurance, if the doctor does not accept my insurance, or my insurance eligibility cannot be determined, ***I will pay in full at time of service.***

3. I understand that my coverage is an agreement between myself and my insurance company. It is my responsibility to supply OBGYN Physicians with the current insurance information in a timely manner to ensure payment of medical bills.

4. I understand that any information your practice obtains regarding my benefits is not a guarantee of coverage and is subject to change. It is my responsibility to know what my in and out of network coverage is, as well as my co-insurance and deductible amounts.

5. **I understand that if I addresss additional issues, other than preventative, at the time of my annual/well woman visit I may be liable for my applicable deductable or copay amounts if so dictated by my insurance policy.**

**By signing my name below, I certify that I have read the above information.
My signature also certifies my understanding of and agreement with the above policies.**

Patient Name ____________ Patient Signature ____________ Date ____________

Legal Guardian / Authorized Individual Signature (if applicable) ____________

HIPAA

OBGYN Physicians understands that your medical/health information is personal and private. In order to provide you with quality care and to ensure compliance with certain legal requirements, we create a record of care and services you receive in our office. We respect the privacy and confidentiality of medical/health information about you and that can be identified with you. This is called "protected health information." At the front desk, a copy of our privacy policy is available upon request. The policy outlines your privacy rights. Please take the time to review them.

1. I authorize OBGYN Physicians to release all my medical information pertaining to my exam/treatment, including HIV or alcohol related information to my insurance company(ies) for the purposes of processing insurance claims. This release may include the reviewing and/or photocopying pertinent documents for the purposes of payment by my insurance company(ies). I authorize the payment of medical insurance benefits to be made directly to the above named practice. I permit a copy of this authorization to be used in place of the original

2. I grant OBGYN Physicians to call my preferred number to confirm appointments, inform me of lab results, or leave a brief message. I grant OBGYN Physicians to send reminder notices by mail. I grant OBGYN Physicians to fax or receive information to/from treating physicians/hospitals.

By signing my name, I certify that I have read the HIPAA information and that it certifies my understanding of along with my agreement with the policies.

(Print Patient Name) (Patient Signature)