MODERN OB-GYN

APPOINTMENT DATE:_____

PATIENT INFORMATION (Please Print)

_____ _____ _____ _____/_____/_____ _____

Last Name **First Name** **M.I.** **Date of Birth** **Driver License #**

_____ _____ _____ _____

Address **City** **State** **ZIP**

_____ _____ _____ _____

Social Security # **Home Phone** **Cell Phone** **Religious Preference**

Circle preferred daytime contact # Home / Cell / Work / other **Leave message on machine? Y or N** **Message with household member? Y or N**

Marital Status _____ **Single** _____ **Married** _____ **Divorced** _____ **Widowed** _____ **Separated** _____ **Other** _____ _____ **Declined**

EMPLOYER INFORMATION

_____ _____

Employer **Occupation**

EMERGENCY CONTACT (Name and Telephone #) _____

OTHER PROVIDERS

_____ _____

Primary Care Physician **PCP Location**

_____ _____

Referring Physician **Referring Physician Location**

PHARMACY NAME_____ PHARMACY ADDRESS_____

INSURANCE INFORMATION

INSURANCE POLICY HOLDER (Circle One: Self / Spouse / Significant Other)

_____ _____ _____ _____/_____/_____ _____

Last Name **First Name** **M.I.** **Date of Birth** **Sex**

_____ _____ _____ _____ _____

(Address if different from Patient) **City** **State** **ZIP** **Phone**

_____ _____ _____

Social Security # **Employer** **Occupation**

PRIMARY INSURANCE COMPANY INFORMATION:

(Please circle one) BCBS, Aetna, Cigna, HAP, UMR, Priority Health, Tricare, Cofinity, Medicaid, Medicare, Other _____

Policy Holder_____ **Type of Policy: (Please circle one) PPO, HMO, POS, EPO, Traditional**

Member #/Enrollee ID: _____ _____ **Group #** _____

Insurance Claims Address: (Usually a P.O. Box Address on the back of card) _____ _____

SECONDARY INSURANCE COMPANY INFORMATION:

(Please circle one) BCBS, Aetna, Cigna, HAP, UMR, Priority Health, Tricare, Cofinity, Medicaid, Medicare, Other _____

Policy Holder_____ **Type of Policy: (Please circle one) PPO, HMO, POS, EPO, Traditional**

Member #/Enrollee ID: _____ _____ **Group #** _____

Insurance Claims Address: (Usually a P.O. Box Address on the back of card) _____ _____

Beaumont Records: Y or N In order for us to obtain your Beaumont Records, we are required to provide either your Beaumont Medical Record Number or the last four digits of your Social Security Number. If you have records at Beaumont, please provide one of the following and initial where indicated:

Beaumont MRN: _____ ***Last 4 of SS#:*** _____ ***Initials:*** _____

CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose your health information in our possession.

The use and disclosure by this office are necessary and will be used in connection with treatment, our obtaining payment for the treatment and services that this office provides to you so that this office can conduct its health operations.

For a more complete description of how this office may use or disclose your Protected Health Information, please review the Notice of Privacy Practices Form that this office has prepared and can furnish to you. Please also see our Notice of Privacy Practices Form for a detailed discussion of the meanings of "treatment", "payment", and "health care operations".

You have the right to review our Notice of Privacy Practices Form prior to signing this consent. Please be advised that the Notice of Privacy Practices Form may be revised by this office from time to time. Such revisions of the Notice of Privacy Practices will be made available to you by contacting the office.

You should also review carefully the Notice of Privacy Practices Form because it contains a list of rights that are available to you with respect to this office's use and disclosure of your protected health information. These rights include your right to request restrictions on our use or disclosure of your protected health information.

You have the right to revoke this consent at any time. If you wish to revoke this consent, you may do so in writing.

By signing below, you acknowledge that you have read and understand this consent and this office's Notice of Privacy Practices Form. You further acknowledge that you have received a copy of this office's Notice of Privacy Practice Form to take with you.

_____ _____

Patient Signature **Date**

_____ _____

Witness **Date**

MODERN OB/GYN

AUTHORIZATION AND RESPONSIBILITY AGREEMENT

We invite you to discuss with us any questions regarding our services and policies. The best health services are based on a friendly, mutual understanding between provider and patient.

Your insurance policy is a contract between you and your insurance company. We are not party to that contract. Our relationship is with you, not your insurance company.

I hereby authorize my insurance company to pay directly to Modern OB/GYN, any professional or medical expense benefits for services rendered. If my insurance company does not pay my balance in full within 30 days, I will be responsible for contacting my carrier to inquire about the delay.

I authorize Modern OB/GYN to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release Modern OB/GYN from any consequence thereof. A photocopy of this assignment shall be considered as effective and valid as the original.

I understand it is my responsibility to inform this office of any changes in my medical insurance status. **Initials:** _____

FINANCIAL RESPONSIBILITY:

Our office policy requires payment in full for all services rendered at the time of visit unless otherwise arrangements have been made with the business manager, or current and complete insurance information is submitted. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 60 days past due, a $15 late fee will be added to the balance owed. If an account is turned over to our collection agency, a 50% fee will be added to the account to cover the agency fees.

Returned checks will be accessed a $15 fee each time it is declined by the bank. We will put an NSF check through twice. If payment on a collection account is returned, it will be accessed a 50% fee. **Initials:** _____

CANCELLATION POLICY:

We request that if you must reschedule your appointment, you provide our office with 24 hours notice. If you are unable to give appropriate notice, you will be charged a $50 fee.

Initials: _____

_____ _____

Signature of patient or responsible person **Date**

NEW GYN RECORD

APPOINTMENT DATE _____

NAME _____ **PRIMARY PHYSICIAN** _____

BIRTHDATE _____ **AGE** _____ **REFERRED BY** _____

MEDICATIONS (Including Vitamins):

Medication	Dosage	Directions

ALLERGIES:

Medication	Reaction

PHYSICIAN COMMENTS (Office Use Only)

WHAT IS THE REASON FOR TODAY'S VISIT?

_____

_____

_____

CC: _____

HPI: _____

_____

_____

_____

MENSTRUAL HISTORY:

Age of 1st Period _____ **Date of Last Menstrual Period** _____

Number of days between start of one period to start of the next _____

Number of days of flow _____ **Are periods regular?** Yes or No

Amount of flow: Light/Medium/Heavy **Are periods painful/crampy?** Yes or No

Do you have bleeding between periods? Yes or No **After intercourse?** Yes or No

GYNECOLOGY HISTORY: *(Circle all problems in your past or present history)*

Abnormal Pap Date _____ **Results** _____ **Treatment** _____

Venereal Warts/Condyloma **Pelvic Inflammatory Disease**

Chlamydia /Gonorrhea/Syphilis/Herpes **Recurrent Vaginal Infections**

Recurrent Bladder Infections/Ovarian Cysts/ Endometriosis/Fibroid Uterus/Infertility

PMS: Depression **Anxiety** **Fluid Retention** **Breast Soreness** **Other**_____

Menopausal Symptoms: Hot Flashes/Night Sweats/ Vag. Dryness/Other _____

Sexual Problems: Decreased Sex Drive **Painful Sex** **Other** _____

Breast Problems: Hx of Cancer/Discharge/Abn Mammogram/Implants/Reduction

Past Biopsy Date_____ **Results** _____

Birth Control Method_____

MEDICAL HISTORY: *(Check all problems in your past or present history)*

Chicken Pox	_____	**Chronic Lung Disease**	_____	**Tuberculosis**	_____
Asthma	_____	**Heart Disease**	_____	**Hypertension**	_____
High Cholesterol	_____	**Mitral Valve Prolapse**	_____	**Heart Murmur**	_____
Stroke	_____	**Headaches**	_____	**Seizures**	_____
Kidney Stones	_____	**Kidney Infections**	_____	**Ulcers/Reflux**	_____
Liver Disease	_____	**Hepatitis/Jaundice**	_____	**Irritable Bowel**	_____
Gall Stones	_____	**Diabetes**	_____	**Thyroid Disease**	_____
Arthritis	_____	**Anemia**	_____	**Blood Transfusion**	_____

NEW GYN RECORD

APPOINTMENT DATE _____ **Pg 2**

NAME _____ **PHYSICIAN COMMENTS (Office Use Only)**

Cancer _____ **Glaucoma** _____ **Hearing Problem** _____ _____

Major Accident _____ **Depression/Anxiety** _____ **Osteoporosis** _____ _____

REVIEW OF SYSTEMS: *(Circle all Current Problems)* _____

1. **Constitutional: Weight Loss, Weight Gain, Fevers, Fatigue** _____
2. **Eyes: Contacts/Glasses, Double Vision, Spots before Eyes** _____
3. **ENT: Earaches/Ringing, Sinus Problems, Sore Throat/Mouth, Dental Problems** _____
4. **CV: Palpitations, Chest Pain, Difficulty Breathing, Leg Swelling** _____
5. **Respiratory: Wheezing, Spitting up Blood, Shortness of Breath, Chronic Cough** _____
6. **GI: Diarrhea, Bloody, Nausea/Vomiting, Constipation, Hemorrhoids, Incontinence** _____
7. **Urinary: Blood, Pain, Urgency, Frequency, Incontinence, Incomplete Emptying** _____
8. **Musculoskeletal: Muscle Weakness, Joint Pains, Low Back Pain** _____
9. **Skin/Breast: Breast Pain, Discharge, Masses, Rash, Ulcers, Acne, Facial Hair** _____
10. **Neurological: Dizziness, Seizures, Numbness, Trouble Walking** _____
11. **Psychiatric: Depression, Crying, PMS, Sleep Disorder, Eating Disorder** _____
12. **Endocrine: Dry Skin, Abnormal Thirst, Hair Loss, Vocal Changes** _____
13. **Hematologic/Lymphatic: Bruising Enlarged Lymph Nodes, Abnormal Bleeding** _____
14. **Allergy/Immunologic: Environmental Allergies/Food Allergies/Immune Problem** _____

OBSTETRICAL HISTORY: **(List all pregnancies including live births, stillbirths, miscarriage, abortions, and tubal pregnancies)**

Date	Hospital	Length of Pregnancy	Duration of Labor	Type Delivery	Problems
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

SURGERY/HOSPITALIZATIONS

Year	Operation/ Medical Problem
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Occupation_____ **Marital Status** Single/Married/Widow/Divorced/Other

Sexual Preference Heterosexual/Homosexual/Bisexual/Other **Do you smoke?** Yes or No **Number cigarettes per day** _____

Do you drink alcohol? Yes or No **Number drinks per week**_____ **Do you use recreational drugs?** Yes or No **Type**_____

Do you ALWAYS wear a seatbelt in the car? Yes or No **Do you have problems with Verbal/Physical abuse?** Yes or No

Do you follow a special diet? Yes or No **Type of Diet**_____

NEW GYN RECORD

APPOINTMENT DATE _____
NAME _____

FAMILY HISTORY:

Please indicate which family members have the following conditions (past or present).

Heart Disease _____ **Ovarian Cancer**_____ **Birth Defects**_____

Hypertension _____ **Breast Cancer**_____ **Osteoporosis**_____

High Cholesterol_____ **Uterine Cancer**_____ **Colon Cancer**_____

Diabetes_____ **Other Significant History** _____

Mom: Name_____ **Alive/Deceased Age** _____ **Health Issues**_____

Dad: Name_____ **Alive/Deceased Age**_____ **Health Issues**_____

Siblings: 1. Name_____ **Alive/Deceased Age**_____ **Health Issues**_____

2. Name_____ **Alive/Deceased Age**_____ **Health Issues**_____

3. Name_____ **Alive/Deceased Age**_____ **Health Issues**_____

4. Name_____ **Alive/Deceased Age**_____ **Health Issues**_____

5. Name_____ **Alive/Deceased Age**_____ **Health Issues**_____

SCREENING TESTS/VACCINES: (List most recent date)

Pap smear _____ **Normal / Abnormal**

Mammogram_____ **Normal / Abnormal**

Cholesterol _____ **Normal / Abnormal**

Sigmoid/Colonoscopy_____ **Normal / Abnormal**

EKG/Stress Test_____ **Normal / Abnormal**

Bone Density_____ **Normal / Abnormal**

TB Skin Test_____ **Normal / Abnormal**

Rubella Immunity_____ **Yes / No**

Chicken Pox Immunity_____ **Yes / No Chicken Pox Vaccine**_____

TDAP _____ **Tetanus Booster**_____

Flu shot_____ **Pneumonia Vaccine**_____ **Zoster Vaccine**_____

Gardisil 1._____ **2.**_____ **3.**_____

Please List Any Additional Issues or Comments to Address

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____