Please bring your insurance cards and a list of medications to all appointments.

Physician: _____ Preferred Pharmacy/City: _____

Last Name: _____ First Name: _____ Middle Initial: ___Preferred Name: _____

Date of Birth: _____ Sex: M F Social Security Number: _____

Race: __African Amer./Black __Amer. Indian/Alaskan Native __Asian __Caucasian/White __Nat Hawaiian/Pacific Islander __Other

Ethnicity: __ Hispanic or Latino __ Not Hispanic or Latino __ Declined Primary Language: _____

Marital Status: __ Single __ Married __ Widowed __ Divorced Other: _____

Driver's License: _____ Religion: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (___) _____ Work #: (___) _____ **Cell #**: (___) _____

E-mail Address: _____ Preferred Method of Contact: __Phone __Mail __Patient Portal

Were you referred to our practice by another physician __Yes __No If so, Name: _____

Primary Care Physician: _____ Emergency Contact Phone #: _____

Insurance: **MUST PRESENT CARD AT TIME OF VISIT OR PAYMENT WILL BE REQUIRED IN FULL**

Primary Insurance: _____Policyholder/Name on Card: _____

Secondary Insurance: _____ Policyholder: _____

Patient's Employer (if not applicable, insert "n/a"):_____

Spouse or Parent's Name: _____ Date of Birth: ____/____/_____

Spouse or Parent's Employer: _____ Social Security Number: _____

ASSIGNMENTS OF BENEFITS

I request payments by Medicare, Medicaid, medical insurance companies and other third party payers be made payable to my healthcare providers. I authorize my physicians and healthcare providers to release my Protected Health Information (PHI) to the healthcare Financing Administration, insurance companies, and other providers of medical services as may be necessary to provide for my clinical care and/or to determine my financial benefits or coverage's, in compliance with HIPAA and other applicable laws. I hereby acknowledge I have received a Notice of Privacy Practices. I understand and agree I am responsible for any charges not paid for by my insurance.

Signature of Patient or Legal Guardian: _____ Date: _____

St. Bernards OB-GYN ASSOCIATES

Please spend a few minutes and answer the following questions. Your doctor needs some basic information about your medical history in order to provide you with more effective medical care. We will also need to make a copy of your current insurance card. Thank you for your time.

Your Name: _____ Age: _____ Date of Birth: ___/____/_____
Do you have a primary care physician? If so, please print his/her name: _____

What is the reason for your appointment?

- ☐ **Specific gynecological problem**
- ☐ **Routine/wellness/preventative physical. <u>If your insurance does not have wellness coverage, you will be responsible for the charges for your annual exam.</u>**

What is the date of your appointment?
_____

If problems, what are symptoms? How long have symptoms been present? Have you received any treatment for this problem? Please explain._____
_____

Personal and Family History. Place an X in the appropriate boxes that apply.

	Self	Mother	Father	Sister	Brother	Aunts	Uncles	Grandmother	Grandfather
Breast Cancer									
Ovarian Cancer									
Uterine Cancer									
Colon Cancer									
Colon Polyps									
High-Blood Pressure									
Diabetes									
Stroke									
Heart Attack									
Heart Disease									
Osteoporosis									
Other									

Pregnancy History. Write in the number for each of the following.

# of Pregnancies	# of Premature Births	# of Miscarriages	# of Induced Abortions	# of Live Births

Do you plan to have more children? __Yes __No __Undecided

Please continue to next page

Have you ever had a blood transfusion? __Yes __No

What medicines are you taking? Include birth control pills. (Include dose and how often)

1.
2.
3.

What medicines are you allergic to?

1.
2.
3.

Please check (X) surgeries you have had for removal or repair of the following:

		Date	Comments
Tonsils			
Ears			
Appendix			
Gallbladder			
Tubal ligation			
Hysterectomy (removal of uterus)			
Removal of ovaries (left, right, both)			
Hernia			
Hemorrhoids			
Breast Biopsy			
Mastectomy			
C-Section			
Breast Implants			
D&C			
Laparoscopy			

Please list the last date of the following immunizations: (if unsure, list approximate year)

TB skin test and/or chest x-ray:_____ Rubella: _____

Flu: _____ Pneumonia Vaccine: _____

Diphtheria/Tetanus: _____

Do you smoke? ___Yes ___ No

Do you drink 2 or more alcoholic drinks a day? ___Yes ___ No

Do you use recreational or hard drugs? ___Yes ___ No

Date of last Pap Smear: _____ (If MCR, Nurse check for ABN)