

WELCOME TO OUR OFFICE

Please Complete this form and return it to the receptionist. PLEASE PRINT.

PATIENT NAME _____ DATE OF BIRTH _____

MAILING ADDRESS _____

CITY _____ STATE ____ ZIP _____ PHONE _____

SOCIAL SECURITY # _____ MARITAL STATUS _____

PATIENT'S EMPLOYER _____ WORK PHONE _____

OCCUPATION _____ CELL PHONE _____

IN CASE OF EMERGENCY PLEASE NOTIFY:

NAME _____ RELATIONSHIP TO PATIENT _____

PHONE NUMBER _____ WORK PHONE _____

**** IF MARRIED, PLEASE INDICATE SPOUSE'S NAME AND DAYTIME PHONE****

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

PHONE NUMBER _____ WORK PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO. _____

POLICY NO. _____ GROUP NO. _____ CONTRACT _____

POLICY HOLDER _____ POLICY HOLDER DOB _____

POLICY HOLDER'S EMPLOYER _____

SECONDARY INSURANCE CO. _____

POLICY NO. _____ GROUP NO. _____ CONTRACT _____

POLICY HOLDER _____ POLICY HOLDER DOB _____

POLICY HOLDER'S EMPLOYER _____

DATE SIGNATURE

RELEASE OF INFORMATION

I HERBY AUTHORIZE AND ALLOW BROOME OBSTETRICS AND GYNECOLOGY, PC HAVING TREATED ME, TO RELEASE TO GOVERNMENTAL AGENCIES, HOSPITALS, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE, ALL INFORMATION NEEDED FOR MEDICAL TREATMENT, HEALTHCARE OPERATIONS AND TO SUBSTANTIATE PAYMENT FOR SUCH MEDICAL CARE TO PERMIT REPRESENTATIVE THEREOF TO EXAMINNE AND MAKE COPIES OF ALL RECORDS, INCLUDING HIV, RELATING TO SUCH CARE AND TREATMENT.

SIGNATURE OF PATIENT/AUTH REPRESENTATIVE

DATE

INSURANCE ASSIGNMENT

I HERBY ASSIGN, TRANSFER AND SET OVER TO BROOME OBSTETRICS AND GYNECOLOGY PC SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT IN SAID MEDICAL GROUP.

SIGNATURE OF PATIENT/AUTH REPRESENTATIVE

DATE

PRIVACY RELEASE

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES OF BROOME OBSTETRICS AND GYNECOLOGY, PC.

SIGNATURE OF PATIENT/AUTH REPRESENTATIVE

DATE

MEDICARE RELEASE

I CERTIFY THAT THE INFORMATION GIVEN TO ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, OR ITS CARRIERS, ANY INFORMATION REQUIRED TO PROCESS MY MEDICAL CLAIMS. I REQUEST PAYMENT TO BE MADE TO BROOME OBSTETRICS AND GYNECOLOGY, PC.

SIGNATURE OF PATIENT/AUTH REPRESENTATIVE

DATE

PAYMENT AND/OR CO-PAYS ARE DUE AT THE TIME OF SERVICE

Patient Name _____ DOB _____

FAMILY HISTORY

Illness	Relative	Age onset	Illness	Relative	Age onset
Y N Breast Cancer	_____	_____	Y N Ovarian Cancer	_____	_____
Y N Colon Cancer	_____	_____	Y N Other Cancer	_____	_____
Y N Heart Disease	_____	_____	Y N Hypertension	_____	_____
Y N Depression/Anxiety	_____	_____	Y N Stroke	_____	_____
Y N Thyroid Disease	_____	_____	Y N Osteoporosis	_____	_____
Y N Bleeding Disorders	_____	_____	Y N Mental Retardation	_____	_____
Y N Birth Defects	_____	_____	Y N Genetic Disease	_____	_____
Y N Diabetes	_____	_____	Y N Other	_____	_____

SOCIAL HISTORY

Tobacco Use Y N How Much _____ Number of Years _____
Alcohol Use Y N How Much _____
Recreational Drug Use Y N How Much _____ Number of Years _____
Calcium Intake Y N Calcium Supplement Y N _____
Caffeine Intake Y N How Much _____
Exercise Y N How often _____ Type _____

MEDICATIONS (INCLUDING OVER THE COUNTER)

Medication	Medication	Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

See Attached List _____

MENSTRUAL HISTORY

Age at first menstrual period _____
Cycle length _____ Flow length _____
Menstrual flow – Light _____ Moderate _____ Heavy _____

If you have stopped having menstrual periods, at what age did you have your last one _____

Date Updated and Reviewed _____

Patient Name _____ Date _____
 Date of Birth _____ Primary Care Physician _____
 Referred By _____ Physician Address _____
 Specialists _____

ALLERGIES (REACTIONS) _____ (_____)
 _____ (_____) _____ (_____)

MEDICAL HISTORY

Y N Heart Disease _____	Y N Hypertension _____	Y N High Cholesterol _____
Y N Stroke _____	Y N Bleeding Disorders _____	Y N Mitral Valve Prolapse _____
Y N Asthma _____	Y N Thyroid Disease _____	Y N HIV _____
Y N Osteopenia _____	Y N Osteoporosis _____	Y N Joint Replacement _____
Y N Diabetes _____	Y N Anxiety/Depression _____	Y N Migraines _____
Y N GERD _____	Y N Peptic Ulcer Disease _____	Y N Transfusion HX _____
Y N Cancer _____	Y N Seizures _____	Y N STD Exposure _____

Other _____

FAMILY PLANNING _____

OPERATIONS/HOSPITALIZATIONS

Date	Procedure	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OBSTETRICAL HISTORY G _____ T _____ Pt _____ A _____ L _____

Date	Type of Delivery (Complications)	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DEXA Scan Y N Date's _____
 Colonoscopy Y N Date's _____
 Gardasil Vaccine's Y N Date's _____

Date Updated and Reviewed _____

Name: _____ Date: _____ Medical Doctor: _____

Last menstrual period: _____ Medications: _____

Please check any of the following symptoms that apply to you. Thank You.

CONSTITUTIONAL	YES	NO	MUSCULOSKELETAL	YES	NO
Weight loss	—	—	Muscle weakness	—	—
Weight gain	—	—	Muscle/joint pain	—	—
Change in height	—	—	SKIN		
Fever	—	—	Bruises	—	—
EYES/EARS/NOSE/THROAT			Rash	—	—
Vision changes	—	—	Changes in moles	—	—
Earaches	—	—	BREASTS		
Hearing problems	—	—	Pain in breasts	—	—
Sore throat	—	—	Nipple discharge	—	—
Mouth sores	—	—	Lumps	—	—
CARDIOVASCULAR			NEUROLOGIC		
Chest pain	—	—	Seizures	—	—
Swelling of legs	—	—	Dizziness	—	—
Rapid/irregular heartbeat	—	—	Numbness	—	—
RESPIRATORY			Frequent/severe headaches	—	—
Coughing up blood	—	—	PSYCHIATRIC		
Shortness of breath	—	—	Feeling down/sad	—	—
Chronic cough	—	—	Feeling anxious	—	—
Wheezing	—	—	ENDOCRINE		
GASTROINTESTINAL			Heat/cold intolerance	—	—
Frequent diarrhea	—	—	Abnormal thirst	—	—
Bloody stool	—	—	Hot flashes	—	—
Nausea/vomiting	—	—	Chronic fatigue	—	—
Constipation	—	—	HEMATOLOGIC/LYMPHATIC		
Change in bowel habits	—	—	Cuts that do not stop bleeding	—	—
Abdominal bloating	—	—	Enlarged lymph nodes/glands	—	—
Frequent indigestion	—	—	ALLERGIC/IMMUNOLOGIC		
Hemorrhoidal pain	—	—	Medication allergies?	—	—
URINARY			List: _____		
Blood in urine	—	—	Other allergies?	—	—
Pain with urination	—	—	List: _____		
Strong urgency to urinate	—	—	Do you drink alcohol?	—	—
Frequent urination	—	—	How much? _____		
Incomplete emptying	—	—	Do you smoke?	—	—
Involuntary urine loss	—	—	How much? _____		
Urine loss w/cough/lift	—	—	Do you exercise?	—	—
GYNECOLOGICAL			Would you like information on domestic violence?	—	—
Abnormal bleeding	—	—			
Painful periods	—	—			
Painful intercourse	—	—			
Abnormal vaginal discharge	—	—			
Itching	—	—			
Possible contact with sexually transmitted disease	—	—			
Bleeding with intercourse	—	—			

