DR. ELAINE PAUL, DR. BETH BOYLES, DR. MELISSA BOYLES,
DR. RONDA GAISER, DR. CYNTHIA VANEK, DR. ERIN SCHNACKEL

WOMEN PHYSICIANS IN OBGYN, INC.
PLEASE CHECK NEW PATIENT ____ PREVIOUS PATIENT____
COMPLETE THE FOLLOWING INFORMATION AND RETURN AS SOON AS POSSIBLE

PATIENT FIRST NAME, MIDDLE INITIAL AND LAST NAME ____

MAIDEN NAME/PREVIOUS NAME______________________________________

ADDRESS____

HOME# _________________________ WORK#________________________ CELL#_____________________________

AGE_____ DOB _________________ SOCIAL SECURITY # (REQUIRED) _____________________________________

MARITAL STATUS __________________ EMPLOYER NAME____________________________________

SPOUSES FIRST NAME, MIDDLE INITIAL AND LAST NAME____

DOB___________________ SOCIAL SECURITY # (REQUIRED) ____

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT FROM PATIENT):

FIRST NAME, MIDDLE INITIAL AND LAST NAME____

ADDRESS____

HOME# _________________________WORK#______________________________CELL#__________________________

RELATIONSHIP____

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED AT THIS OFFICE? CIRCLE Y / N

NEAREST LIVING RELATIVE (NOT LIVING WITH YOU) ______________________________________

TELEPHONE#____

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED-ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE.

TO THE EXTENT NECESSARY TO DETERMINE LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT, I AUTHORIZE DISCLOSURE OF PORTIONS OF THE PATIENT'S RECORD. I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING PRIVATE INSURANCE AND OTHER HEALTH PLANS TO WOMEN PHYSICIANS IN OBGYN, INC. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IF A CHARGE IS PAID BY ME, THEN LATER PAID TO MY PROVIDER BY MY INSURANCE COMPANY, I WILL BE REIMBURSED. I HEREBY AUTHORIZE WOMEN PHYSICIANS IN OBGYN, INC. TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT.

PATIENT SIGNATURE____ DATE SIGNED_______________________

PRESENT
COMPLAINTS____

LIST ALL DRUG
ALLERGIES____

LIST ALL MEDICAL ILLNESSES OR
HOSPITALIZATIONS____

LIST ALL MEDICATIONS YOU ARE PRESENTLY ON____

LIST ALL SURGICAL OPERATIONS____

MENSTURAL HISTORY:

AGE STARTED______ HOW OFTEN__________________________ ARE YOU REGULAR Y / N
DURATION DAYS (FROM START TO STOP)

FLOW: LIGHT____ LIGHT____ MODERATE____ HEAVY CLOTS____

PAIN: NON____ MILD____ MODERATE____ SEVERE____

HAVE YOU EXPERIENCED ANY SPOTTING OR BLEEDING BETWEEN PERIODS? Y / N

FIRST DATE OF LAST 2 MENSTRUAL PERIODS ________________________ AND_____________________________

TYPE OF BIRTH CONTROL, IF ANY YOU ARE USING____

DATE OF LAST PAP SMEAR_______________________

PREGNANCY (LIST DATES)____

NUMBER OF PREGNANCIES__________________

NUMBER OF LIVING CHILDREN_________________

ARE YOU SEXUALLY ACTIVE? Y / N IF YES, AT WHAT AGE? _______ # OF PARTNERS IN THE LAST YEAR_________

WHO IN YOUR IMMEDIATE FAMILY HAVE EVER HAD THE FOLLOWING?

CANCER, DIABETES, HEART TROUBLE, HIGH BLOOD PRESSURE, MENTAL RETARDATION, GENETIC DISEASE,

SEIZURES, STROKE, BIRTH DEFECTS, BLOOD PRESSURE____

____

CHECK ANY OF THE FOLLOWING THAT YOU HAVE EVER HAD:

__FREQUENT HEADACHES
__VISION PROBLEMS
__CONVULSIONS OR PARALYSIS
__DIZZY SPELLS
__SHORTNESS OF BREATH
__RECURRENT CHEST PAIN
__ASTHMA
__HEAR MURMUR
__EASY BRUISING OR BLEEDING
__RHEUMATIC FEVER
__EMPHYSEMA
__ BLOOD CLOT IN VEINS
__VOMITING OF BLOOD
__HERPES

__HERNIA
__INCONTINENCE
__BLOOD IN URINE
__RECURRENT BLADDER INEFECTIONS
__BURNING WITH URINATION
__BLOOD IN STOOL
__PERSISTENT / SEVERE ABDOMINAL PAIN
__PERSISTENT NAUSEA OR VOMITING
__RECURRENT DIARRHEA
__HISTORY OF ALCOHOLISM
__PRESENTLY SMOKING
__ACHING OR PAINFUL JOINTS
__DIABETES
__THYROID PROBLEMS

__HIGH BLOOD PRESSURE
__BLOOD TRANSFUSION
__RECENT WEIGHT CHANGE
__HEPATITIS
__JAUNDICE
__EMOTIONAL PROBLEMS
__SEXUAL DIFFICULTIES
__VENEREAL DISEASE
__PSYCHIATRIC HELP
__DRUGS (LSD, COCAINE…)
__COUGHING WITH BLOOD
__HIV RISK FACTORS