PATIENT INFORMATION SHEET

PATIENT'S NAME:_____
LAST FIRST MI MARITAL STATUS

SS NUMBER:_____ DOB:_____ HOME PHONE#:_____

ADDRESS:_____
STREET NO. & NAME CITY STATE ZIP CODE

EMPLOYER:_____/_____
WORK PHONE #

SPOUSE'S NAME:_____/_____/_____
SS# DOB

SPOUSE'S EMPLOYER:_____/_____
WORK PHONE #

EMERGENCY CONTACT:_____/_____/_____
RELATIONSHIP DAYTIME PHONE#

REFERRED BY:_____ PCP_____
NAME / PHONE #

INSURANCE

Does your insurance allow a routine GYN exam (Well Woman)? Y or N

Do you have a Primary Care Physician? Y or N Does your insurance require a referral? Y or N

Primary Insurance:_____
Name Address Phone #

Policy Holder:_____ DOB:_____ SS#:_____

Policy or ID#:_____ Group #:_____

Secondary Insurance:_____
Name Address Phone #

Policy Holder:_____ DOB:_____ SS#:_____

Policy or ID#:_____ Group#:_____

I acknowledge that payment be made directly to the physician for any medical services received.
Signature X_____ Date_____

I hereby authorize the physician to release any information acquired during the course of my examination/treatment to any lab, physician, hospital, or pharmacy involved with my continuity of care.
Signature X_____ Date_____

I authorize the transmission of my medical records by fax if the necessity should arise without additional written request.
Signature X_____ Date_____

I give authorization to the physician and/or staff to leave medical information including appointment info and/or results on my answering machine at home and/or work or with individual noted:_____
SignatureX_____ Date_____

I understand the above authorizations are effective from the date noted above until further notice unless a written request is received by the physician._____
INITIAL

PLEASE COMPLETE BOTH SIDES
PATIENT HEALTH HISTORY

NAME _____ DATE _____
LAST FIRST MI

ADDRESS _____
STREET / APT # CITY STATE ZIP CODE

D.O.B. _____ SS# _____ MARITAL STATUS _____

PHONE(____) _____ (____) _____ EMPLOYER _____
HOME WORK

NAME OF SPOUSE/GUARDIAN _____ PHONE _____

INSURANCE NAME _____ INSURED'S NAME _____

CHIEF COMPLAINT(WHY ARE YOU IN THE OFFICE TODAY?)

_____

DO YOU HAVE A LIVING WILL? _____YES _____NO

PAST, FAMILY AND SOCIAL HISTORY:

PAST HISTORY:

Prior major illnesses and injuries: _____

Prior operations: _____

Current medications (prescriptions and over the counter): _____

Do you have any reactions/allergies to medicines? _____

Are your immunizations current?

MMR-Measles, Mumps, Rubella—___yes___no
Chicken Pox—___yes___no
Polio—___yes___no
TD—Tetanus-Diptheria—___yes___no
Pneumoccal—___yes___no
Flu Vaccine—___yes___no
Hepatitis B—___yes___no

Have you had any transfusions?___yes___no If yes, list date (s).____

Have you had these infections in the past?

Rheumatic Fever—___yes___no
Hepatitis A—___yes___no
German Measles—___yes___no
Hepatitis B—___yes___no
Chicken Pox—___yes___no

FAMILY HISTORY: Has any relative had any of the following illnesses?

	RELATIONSHIP		RELATIONSHIP
Cancer—___yes___no		Stroke—___yes___no	
Location		Kidney Dis-___yes___no	
Diabetes—___yes___no		Epilepsy—___yes___no	
Heart Disease—___yes___no		Suicide—___yes___no	
High Blood Pres—___yes___no		Mental Ill—___yes___no	
Tuberculosis—___yes___no			

SOCIAL HISTORY:

Do you use drugs?___yes___no If yes, name of drug: _____
Do you use tobacco?___yes___no If yes, number smoked per day: _____
Do you use alcohol?___yes___no If yes, amount consumed per day: _____

Have you ever been physically or sexually abused?___yes___no

PLEASE CHECK IF YOU HAVE EVER HAD THE FOLLOWING PROBLEMS:

Any skin rashes:
___Bumps
___Itching
___Dryness
___Color change in hair/nails
___Chicken pox

Any head injury:
___Frequent or severe
___Headaches

Any eye disease:
___Injury
___Impaired sight

Any ear disease:
___Injury
___Impaired hearing

Any problem with nose:
___Mouth
___Sinuses
___Throat
___Neck

Any breast problems:
___Lumps
___Nipple discharge
___Pain
___Tenderness

Any chest problems such as:
___Chronic coughing
___Asthma
___Wheezing
___Emphysema
___Pneumonia
___Spitting of blood
___Pain
___Shortness of breath

Any heart trouble:
___High blood pressure
___Rheumatic fever
___Heart murmurs
___Chest pain
___Palpitations
___Swelling
___Past EKG or other heart test

Any trouble swallowing:
___Indigestion
___Constipation
___Diarrhea
___Change in bowel habits
___Rectal bleeding
___Black stools
___Hemorrhoids
___Liver or gall bladder trouble
___Hepatitis

Any urinary trouble:
___Frequent urination
___Painful urination
___Leaking of urine when cough/sneeze

Bladder/Kidney:
___Infections
___Stones

Any joint pain:
___Arthritis
___Backache
___Muscle pains/cramps
___Varicose veins
___Blood cells
___Inflammation in veins

Any thyroid trouble:
___Heat/cold intolerance
___Excessive sweating
___Excessive thirst
___Excessive hunger
___Excessive urination
___Diabetes

Any nervousness:
___Tension
___Moodiness
___Depression
___Anxiety

Any trouble with fainting:
___Blackouts
___Seizures
___Local weakness
___Numbness
___Tingling
___Tremors
___Memory loss

Any problems with:
___Anemia
___Easy bruising
___Bleeding
___Blood transfusions
when_____

Any problems with swelling of lymph nodes_____

OTHER_____
_____
_____

GYNECOLOGIC HISTORY:

Age at onset of menses_____ Are they regular?_____ Cycle_____days (from start to start) How long do they last?____
Flow___light___moderate___heavy Do you have pain or cramps?_____ Date of last period?_____
Are you taking birth control pills now?____If yes, what?_____ Do you have side effects from birth control pills?_____
Please check any of the following birth control methods you have used:___condoms ___foam ___Depo Provera injections
___diaphragm ___IUD ___tubal ligation ___vasectomy OTHER_____
Date of last Pap smear_____Was it normal?_____Do you have any history of abnormal Pap smears?_____
History and/or treatment of infertility?_____Number of Pregnancies____ miscarriages____ deliveries____ living___
Have you had any of the following sexually transmitted diseases?____herpes ____chlamydia ____gonorrhea ___AIDS
____syphilis ___genital warts.
Have you had any of the following?____vaginal infection _____discharge ____itching
Have you had any of the following symptoms of menopause? ____night sweats ____hot flushes ____irritability
____heart palpitations ____vaginal dryness ____irregular menses
If postmenopausal, do you ever experience any vaginal bleeding?_____

PATIENT'S SIGNATURE_____DATE_____

PHYSICIAN'S SIGNATURE_____DATE REVIEWED:_____

PHYSICIAN'S SIGNATURE_____DATE REVIEWED:_____

PHYSICIAN'S SIGNATURE_____DATE REVIEWED:_____

BARBARA NYLANDER, MD / CARL E. WINGO, MD / JACKSON COTHREN, MD
SALLY YEAGLEY, NP AND ANNE MOORE, NP
FINANCIAL POLICY

1. All charges incurred for services in the office will be payable at the time of service unless other arrangements are made.

2. All co-payments are due prior to service being provided.

3. There will be a $25.00 service charge on all returned checks.

4. The deductible and co-pay may be required in advance for all surgeries. All elective procedures, not covered by insurance must be paid in full prior to the surgery unless other arrangements are made.

5. All OB patients are required to pay any portion of the delivery fee not covered by the end of the seventh month. OB patients are also required to promptly pay for any other services provided during the pregnancy. Care may be discontinued at any time for non-compliance.

6. All contraceptive devices furnished at the office are to be paid at the time service is provided unless prior arrangements made or prior approval from your insurance is received.

7. Patients needing services due to an injury which involves a third party will be responsible for their own account. As a courtesy, we will be glad to file insurance for you.

8. The responsibility for payment of service lies with the person seeking treatment or the person seeking treatment for another. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.

9. All patients seeking infertility services, not covered by insurance must be paid at the time of service.

10. All patients having insurance requiring a referral for OB/GYN services will be required to present the referral before services are provided. Any patient seeking services without a referral must pay for the service in advance or reschedule the appointment.

11. The physicians may discontinue care for any patient due to non-payment or non-compliance.

12. Any patient's account that cannot be collected by our office will be turned over to a collection agency. In this event, payment in full will be required for any future services regardless of insurance coverage. In the event of default, you agree to pay any court costs, attorney fees, cost of collection, and any contingent fees to collection agencies of not less than 35%. Such contingency fee is to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.

_____

Patient/Guarantor Signature Date