Patient Information Form

Patient Information

Patient's Name: Last, First MI	Marital Status	Date of Birth	Age	Race	Social Security #

Street Address	City and State	Zip Code	Home Phone
			Business Phone
Employer	Occupation		Cell Phone
Employer's Street Address	City and State	Zip Code	Driver's License

Spouse's Name	Date of Birth	Age	Race	Social Security #

Spouse's Employer	Occupation	Business Phone
Employer Street Address	City and State	Zip Code

Relative to be Contacted (Other than Spouse)

Relative's Name	Relationship	Home Phone
Relative's Street Address	City and State	Business Phone

Insurance Information

Primary Insurance Company	Address		Phone number
Insured's Name	Date of Birth	Social Security #	Insurance ID #
Relationship to Patient	Employer Name		Group #
Secondary Insurance Company	Address		Phone number
Insured's Name	Date of Birth	Social Security #	Insurance ID #
Relationship to Patient	Employer Name		Group #

Additional Information

Referred By	Family Physician
Has any member of your immediate family been treated here before? (If yes, list her name and relationship)	

CONSENT TO TREAT: I hereby grant permission to the physician in charge of my care and such assistants as he or they may designate to perform or administer all treatments and diagnosis, which in their judgment may be considered necessary or advisable for the patient's well being.
RELEASE OF INFORMATION: I hereby authorize Generations OB/GYN Group, P.A. to release information contained in my medical records to the insurance company or companies, agents or independent contracts thereof, for the purpose of processing my claims for insurance benefits.
FINANCIAL AGREEMENT: The undersigned clearly understand that the payment obligation is the responsibility of the patient and/or undersigned.
ASSIGNMENT OF BENEFITS: I hereby assign Generations OB/GYN Group, P.A., to any interest and benefits provided under my insurance policy or policies. I also understand that any balance not covered by insurance are due and payable by myself and/or the undersigned.

Signature Date

Patient Questionnaire

Patient Name: ______________________________ **Date:** ______________________________

Since your last visit to our office, your life may have changed and this may affect your health. Please help us to provide the best health care for you by completing this short questionnaire:

	Circle One		If yes, please specify:
Have you changed your occupation?	Yes	No	______________________
Do you have any problems at home?	Yes	No	______________________
Has there been any change in your relationship with your husband, partner, or boyfriend?	Yes	No	______________________
Has there been a change in your periods?	Yes	No	______________________
Date of your last period? ______________________			
Do you use a method of contraception?	Yes	No	Do you use it regularly? ______________
If yes, what type? Pills IUD Diaphragm Condoms Natural/Rhythm BTL Spermicide Vasectomy			Are you/your partner satisfied with this method? ______________________
Do you want any information about birth control?	Yes	No	______________________
Date of your last Pap test? __________ Results __________			
Do you have any questions about safer sex?	Yes	No	______________________
Do you smoke cigarettes?	Yes	No	How many per day? ______________
Do you use street drugs?	Yes	No	______________________
Do you drink alcohol?	Yes	No	How often? How much? ______________
Have you ever felt the need to cut down on your drinking?	Yes	No	______________________
Are you exercising?	Yes	No	How often? What type? ______________
Have you had any illnesses?	Yes	No	______________________
Have you seen any other doctors recently?	Yes	No	______________________
Are you taking any medicines now?	Yes	No	______________________
Have you ever had a cholesterol test?	Yes	No	When? ______________________

Date of your last mammogram? ______________________ Date of your last stool test? ______________

What brings you to our office today? ____

Do you have any questions, problems, or concerns that you would like to discuss with us today? ______________

Patient Privacy Form

Generations
OB/GYN Group, P.A.

Patient Name

Patient Preference Regarding Communication of Health Information

1. Who to Contact

I hereby give permission to the Generations OB/GYN Group, P.A. to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friend(s):

Name | Relationship

Name | Relationship

Name | Relationship

______________ **I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).**

2. How to Contact

I wish to be contacted in the following manner:

Home Telephone:

- ☐ Ok to leave message with detailed information
- ☐ Leave message with call-back number only

Work Telephone:

- ☐ Ok to leave message with detailed information
- ☐ Leave message with call-back number only

Written Communication

☐ OK to mail to my home address:

Street Address | City, State, Zip Code

☐ OK to mail to my work/office address:

Street Address | City, State, Zip Code

☐ OK to fax to this number: ______________________________

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Signature of Patient or Legal Representative | Date