PATIENT INFORMATION **CONFIDENTIAL** File #: _____

(Please Print) Date: _____

Name:_____ Home Phone #: _____
Last MI First

Birthdate:_____ Social Security Number: _____ Cell Phone #: _____

Address:_____ City:_____ State:_____ Zip: _____

Circle Appropriate Status: Minor Single Married Divorced Widowed Separated

Patient's Employer: _____ Work Phone: _____ Ext: _____

Business Address:_____ City:_____ State:_____ Zip: _____

Spouse Or Parent's Name: _____ Employer: _____ Work Phone: _____ Ext: _____

Whom May We Thank For Referring You? _____

Person To Contact In Case Of An Emergency: _____ Phone: _____

E-Mail Address: _____

May We Send Normal Test Results And Other Information To This E-Mail Address? _____
Signature

INSURANCE INFORMATION

Name Of Insured:_____ Relationship To Patient: _____

Birthdate:_____ Social Security Number: _____ Date Employed: _____

Name Of Employer: _____ Work Phone:_____

Address Of Employer:_____ City:_____ State:_____ Zip: _____

Insurance Company:_____ ID #: _____ Group #: _____

Ins. Co. Address:_____ City:_____ State:_____ Zip: _____

Effective Date Of Insurance Policy:_____

Does Your Insurance Require A Referral From Your Primary Care Physician? ☐ Yes ☐ No

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Do You Have Any Additional Insurance? ☐ **Yes** ☐ **No** **If Yes Complete The Following**

Name Of Insured:_____ Relationship To Patient: _____

Birthdate:_____ Social Security Number: _____ Date Employed: _____

Name Of Employer: _____ Work Phone:_____

Address Of Employer:_____ City:_____ State:_____ Zip: _____

Insurance Company:_____ ID #: _____ Group #: _____

Ins. Co. Address:_____ City:_____ State:_____ Zip: _____

Effective Date Of Insurance Policy:_____

SIGNATURE ON FILE

In order to bill your insurance company for services rendered we need your signature on file.

- I authorize the use of this form on all my insurance submissions
- I authorize release of information to my insurance carrier
- I understand that I am responsible for my bill
- I release this office from all liabilities incurred due to non-reimbursed referrals
- I authorize the doctor to act as my agent to obtain payment
- I authorize payment directly to my doctor
- I permit a copy of this authorization to be used in place of the original

Signature: _____

Atlantic Cape OB/GYN — *Initial Exam Questionnaire*

www.acobgyn.com

Patient's Name: _____ Age: _____ Birth Date: _____ Date of Exam: _____
Primary Care Physician: _____ Last PAP: _____ Last Annual: _____ Last Mammogram: _____

Reason for appointment: _____

Menstrual History

First day of last menstrual period: _____ Age at first period: _____ Are your periods regular? ☐ Yes ☐ No
How many days between period? _____ How many days does your period last? _____
If not getting periods, what age were you when your period stopped? _____
Comments: _____

_____

Obstetrical History

Number of Pregnancies _____ Births _____ Miscarriages _____ Abortions _____
Vaginal births _____ Cesarean births _____ Vaginal births after Cesarean births _____
Comments: _____

_____

Are you sexually active? ☐ Yes ☐ No Current forms of birth control: ☐ **NONE**
If any, please specify: _____

Past Medical & Family History

	Self	**Family**		**Self**	**Family**	**Comments**
Cancer	☐	☐	High Blood Pressure	☐	☐	_____
Osteoporosis	☐	☐	Tuberculosis	☐	☐	_____
Diabetes	☐	☐	High Cholesterol	☐	☐	_____
Heart Disease	☐	☐	Other, specify _____	☐	☐	_____

Have you had *(please check all that apply):* ☐ **NONE**

☐ Abnormal bleeding
☐ Changes in periods
☐ Severe pain with periods
☐ Changes in your breasts
☐ Abnormal vaginal discharge
☐ Vaginal burning or itching
☐ Hot flashes
☐ Poor appetite
☐ Depression
☐ Experienced sexual abuse
☐ Changes in bowel habit
☐ Recent weight change
☐ STD Exposure
☐ STD Screening *(i.e. HIV, Hepatitis B, C, Syphilis, Gonorrhea, Chlamydia)*
☐ Other *(please specify):* _____

Comments: _____

_____

Surgeries or Hospitalizations: ☐ **NONE**
Type of Surgery or Reason for Hospitalization *(Please include dates)*
1. _____
2. _____
3. _____

List any drug/food allergies: ☐ **NONE** If yes, please specify: _____

Medications – Please list ***all*** current medications *(including prescriptions, hormone replacement, vitamins, calcium, and over-the-counter medications)*
☐ **NONE**
Medications:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____