

Birmingham Obstetrics/Gynecology

PATIENT INFORMATION (Please Print)

Name _____ Social Security # _____ - _____ - _____
Last First M.I.

Address _____
Street

City State Zip E-mail _____

Patient's Employer _____ Occupation _____

Patient's Date of Birth _____ Age _____ Marital Status (circle one) S M D W

Race: _____ African American/Blk _____ Asian _____ White _____ Unknown
_____ American Indian/Alaska Native _____ Nat Hawaiian/Pacific Islander _____ Other _____ Declined

Ethnicity: _____ Declined _____ Hispanic/Latino _____
_____ Not Hispanic/Latino _____ Unknown Language _____

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____ Work Phone (____) _____ - _____

If Married, Spouse's Name _____ DOB _____ Employer _____

INSURANCE Please provide insurance card to receptionist.

Insured's Name (if other than patient) _____ Relation to Patient _____ DOB _____

Insured's Employer (if other than patient) _____ Employer Phone #(____) _____

Who were you referred by? _____

Consent for treatment – I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician; his/her nurse or staff.

Authorization for release of information – I authorize the release of any and all my treatment and service information to third parties to facilitate billing, collection or referrals for services to other providers. This includes psychological or psychiatric care, attention and treatment.

Non-covered routine services & collection policy – As your physician, I want to provide you with the best care possible. There may be certain routine services that I feel are necessary for the maintenance of your good health that are not covered by your health insurance contract. We would appreciate your cooperation in paying for these services in a timely manner. This may include but not limited to lab procedures, pathology services, injections, diagnostic tests (i.e. ultrasound and bone density) or in-office surgical procedures. These may not be covered by your contract. Let me assure you that I only order tests I feel are necessary for your good health.

In accepting assignment, the doctors have agreed that the amount allowed by your insurance becomes the total charge for any service. However, patients are responsible for any amount applied to the deductible and the co-insurance amount.

****Birmingham OB/GYN, P.C. and its physicians are not Medicaid providers and claims will not be filed to Medicaid.****

By signing below you accept the responsibility for any costs not covered by your insurance. Also any collection costs, including but not limited to reasonable attorney's fees and court costs.

Private pay – I understand that an initial payment will be due at the time of service. I also understand that I am responsible for any additional charges that may incur from my visit(s).

I have read your policy and agree to be held responsible for the services.

Signature _____ Date _____

Birmingham Obstetrics/Gynecology

Patient History Form – Please Print

Patient's Name _____ Date of Birth _____

Reason for today's visit? _____

Your Medical History

Has anyone in your immediate family ever had the following?

	Yes	No	Who
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you ever had any of the following?

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (High Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted infections (gonorrhea, syphilis, herpes, genital warts)	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis (Blood clots in veins)	<input type="checkbox"/>	<input type="checkbox"/>			

Other _____

Allergies: _____

Do you use:	Yes	No	Drug Reactions	Immunizations Up to Date?
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____	Yes <input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	No <input type="checkbox"/>
Other Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Unknown <input type="checkbox"/>

Surgery: (Please list all surgical procedures)

Date	Procedure	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalizations: (Other than the above surgery or pregnancy)

Date	Procedure	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Menstrual History

When was the first day of your last period? _____ Days between first day of one period to first day of next period? _____ days Length of periods? _____ days

Are your menstrual periods: Regular Irregular Heavy Light Moderate

Do you have bleeding between periods? Yes No

Do you cramp with your periods? Yes No

Pregnancy

List all pregnancies (including term pregnancies, preterm pregnancies, still births, miscarriages, abortions, tubal pregnancies) date type of delivery, and any complications:

Date	Sex	Birth Weight	Type of Delivery	Place of Delivery	Complications
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	_____	_____	_____
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	_____	_____	_____
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	_____	_____	_____
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	_____	_____	_____
_____	M <input type="checkbox"/> F <input type="checkbox"/>	_____	_____	_____	_____

Current Method of Contraception

Birth Control Pills IUD
Condoms Rhythm
Diaphragm Tubal Ligation
Foam or Jelly Vasectomy
Sponge

Is there any problem with sexual function? You Partner

Have you ever had an abnormal pap smear? Yes No

Date of last pap smear: _____ Normal Abnormal

Date of last mammogram: _____ Normal Abnormal

Did your mother take hormones (DES) while pregnant with you? Yes No

Pregnancy Plans

If pregnant, please answer the following:

Are you interested in taking a childbirth class, childbirth refresher course or parenting class? Yes No

Do you plan to: Bottle Feed Breast Feed

Have selected a pediatrician (baby doctor)? Yes No