

OB-GYN Associates of Shreveport – OB Patient Information

NAME: _____ DATE: ___/___/___ BIRTHDATE: ___/___/___

NAME PREFERRED TO BE CALLED: _____ AGE: _____

REFERRED BY: _____

REASON FOR VISIT: ROUTINE OB CARE PROBLEM DESCRIBE PROBLEM: _____

Please fill out each page as completely as possible and sign!

CHECK IF YOU HAD ANY OF THESE MEDICAL ILLNESSES IN THE PAST:

MAJOR ILLNESSES	YES	NO	MAJOR ILLNESSES	YES	NO
Anemia			High Blood Pressure		
Asthma			High Cholesterol		
Blood transfusions			Kidney Stones		
Breast Cancer When? _____			Sexually Transmitted Diseases Type? _____		
Cancer Type? _____			Thyroid Disease		
Chicken Pox			Osteoporosis		
Diabetes			Urinary Tract Infection/Kidney Infection		
Eating Disorder			Other:		
Heart Trouble					

WHEN WAS YOUR LAST TEST?

TEST	DATE	TEST	DATE
Bone Density		Mammogram	
Colonoscopy / Sigmoidoscopy		OTHER:	
Last PAP Smear			
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			

PLEASE LIST ANY OPERATIONS OR PROCEDURES YOU HAVE HAD:

SURGERY/PROCEDURE	DATE	SURGERY /PROCEDURE	DATE
Colposcopy		Endometrial Biopsy	
Cryotherapy		LEEP	
D and C		OTHER GYN:	
Hysterectomy			
<input type="checkbox"/> Vaginal <input type="checkbox"/> Abdominal		OTHER SURGERIES:	
Ovaries Removed Yes <input type="checkbox"/> No <input type="checkbox"/>			

CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES	YES	NO	WHAT BLOOD RELATIVE?	Maternal or Paternal?
Breast Cancer				
Cancer Other Type? _____				
Diabetes				
Gynecological Problems				
Heart Trouble / Murmur				
High Blood Pressure				
High Cholesterol				
Sickle Cell Disease				
Thyroid Disease				
OTHER:				

CIRCLE AND CHECK IF YOU, THE FATHER OF THE BABY, OR ANY BLOOD RELATIVE HAVE:

GENETIC SCREENING	YES	NO	WHO?
Cystic fibrosis			
Down syndrome, mental retardation, autism, fragile X			
Heart defects at birth			
Hemophilia			
Huntington chorea			
Maternal metabolic disorder (insulin dependent diabetes, PKU)			
Medications, drugs alcohol since your last period			
Muscular dystrophy			
Neural tube defects, spina bifida, anencephaly, menigomyelocele			
Patient or father of baby had a child with birth defects not listed above			
Recurrent pregnancy loss or a stillbirth			
Sickle cell disease or trait (African)			
Tay Sachs disease (Jewish, Cajun or French Canadian)			
Thalassemia, Italian, Greek, Mediterranean or Asian Background			
Other inherited genetic or chromosomal disorder			
What:			

YOUR GYN HISTORY

Were you using any birth control when you got pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Condoms	<input type="checkbox"/> Nuvaring		
<input type="checkbox"/> Depo Provera	<input type="checkbox"/> Birth Control Patch		
<input type="checkbox"/> Diaphragm	<input type="checkbox"/> None		
<input type="checkbox"/> IUD- Kind	<input type="checkbox"/> Natural Family Plan/Rhythm		
- Date Inserted:	<input type="checkbox"/> Tubal Ligation		
<input type="checkbox"/> Birth Control Pill	<input type="checkbox"/> Vasectomy		
- Name:	<input type="checkbox"/> Withdrawal		
<input type="checkbox"/> Contraceptive Foam/Jelly	<input type="checkbox"/> Other:		
What age did you have your first period: _____			
How many days are there from start of your period to start of next period?			_____ days
How long does your period last?	_____ days	Flow:	<input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy
Date of Last Period:	_____	Are you sure of the date?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was it a normal period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had a home urine pregnancy test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When: _____
Have you had an office urine pregnancy test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When: _____
Have you had an office blood pregnancy test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When: _____
Have you had recent abnormal bleeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When: _____

YOUR OB HISTORY

	NUMBER		NUMBER
Total # of pregnancies		Full term births	
Premature delivery (less than 37 weeks)		Abortions / Termination	
Miscarriages		Living children	

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight/Sex	Del Type Vag/CSection	Epid Y / N	Preterm Labor?	Wt Gain	Comments / Complications	Hospital
1				M						
				F						
2				M						
				F						
3				M						
				F						
4				M						
				F						

**REVIEW OF SYSTEMS:
PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLIES TO YOU NOW**

CONSTITUTIONAL	NOTES	GENITOURNARY	NOTES
Weight Loss <input type="checkbox"/>		Urgency of urination <input type="checkbox"/>	
Weight Gain <input type="checkbox"/>		Frequency of urination <input type="checkbox"/>	
Hot Flashes <input type="checkbox"/>		Pain with urination <input type="checkbox"/>	
HENT		Nighttime urination <input type="checkbox"/>	
Neck Pain <input type="checkbox"/>		Losing urine <input type="checkbox"/>	
Thyroid Mass <input type="checkbox"/>		Blood in urine <input type="checkbox"/>	
BREAST		Decreased sex drive <input type="checkbox"/>	
Lumps <input type="checkbox"/>		Painful intercourse <input type="checkbox"/>	
Tenderness <input type="checkbox"/>		Possible Pregnancy <input type="checkbox"/>	
Swelling <input type="checkbox"/>		Genital Sores <input type="checkbox"/>	
Discharge <input type="checkbox"/>		Pelvic Pain <input type="checkbox"/>	
Pain in Breast <input type="checkbox"/>		Abnormal Vaginal Bleeding <input type="checkbox"/>	
Abnormal Changes in Breast <input type="checkbox"/>		Painful Periods <input type="checkbox"/>	
GASTROINTESTINAL		ENDOCRINE	
Nausea <input type="checkbox"/>		Loss of Hair <input type="checkbox"/>	
Vomiting <input type="checkbox"/>		Difficulty Tolerating Cold <input type="checkbox"/>	
Diarrhea <input type="checkbox"/>		Difficulty Tolerating Heat <input type="checkbox"/>	
Jaundice <input type="checkbox"/>		HEMATOLOGIC/ LYMPHATIC	
Abdominal Pain <input type="checkbox"/>		Bruises, frequent or easily <input type="checkbox"/>	
ALLERGIC/ IMMUNOLOGIC		Cuts do not stop bleeding <input type="checkbox"/>	
Frequent illness <input type="checkbox"/>		Enlarged lymph nodes <input type="checkbox"/>	
Seasonal Allergies <input type="checkbox"/>		OTHER	
		_____ <input type="checkbox"/>	
		_____ <input type="checkbox"/>	

SOCIAL HISTORY

PLEASE LIST HABITS	
What do you plan to use for contraception after the birth of your baby?	
<input type="checkbox"/> Condoms	<input type="checkbox"/> DepoProvera
<input type="checkbox"/> Foam/Jelly	<input type="checkbox"/> Nuvaring
<input type="checkbox"/> Vasectomy	<input type="checkbox"/> Withdrawal
<input type="checkbox"/> Diaphragm	<input type="checkbox"/> Natural Family Planning/Rhythm
<input type="checkbox"/> IUD	<input type="checkbox"/> Other
<input type="checkbox"/> Birth Control Pill	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> None	
Do you have a cat? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you clean the litter box? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a pediatrician?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Who?	
Are you planning any out of town trips during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you plan to breastfeed your baby? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you plan to have an epidural for labor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What was your pre pregnancy weight? lbs	
Are there any religious or cultural preferences that would affect your care? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What:	
Do you plan to take childbirth classes? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Uses seatbelt? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you've had a Cesarean section, do you want a repeat C-Section? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you have a son, do you want to have him circumcised? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do want your tubes tied after the birth of this baby? <input type="checkbox"/> Yes <input type="checkbox"/> No	

OB/GYN Associates of Shreveport
INFORMATION REGARDING THE PATIENT

Last Name _____ First Name _____ MI _____
(Circle Marital Status)
Date of Birth _____ Age _____ SSN# _____ S M D W Sep
Street Address _____ City, State, Zip _____
Home Phone () _____ Cell Phone () _____
Patient's Employer _____ Business Phone () _____
Spouse Name _____ Cell Phone () _____
Date of Birth _____ Age _____ SSN # _____
Employer _____ Business Phone () _____
Father's Name _____ SSN# _____ Date of Birth _____
(if patient is a minor) Phone # () _____
Employer _____ Business Phone () _____
Mother's Name _____ SSN# _____ Date of Birth _____
(if patient is a minor) Phone # () _____
Employer _____ Business Phone () _____
Nearest relative not living with you _____
Relationship to you _____ Phone # () _____

PERSON RESPONSIBLE FOR PAYMENT AFTER INSURANCE, IF NOT PATIENT

Name _____ Relation to the Patient _____
Billing Address (if different from above) _____

ANY INSURANCE REFERRALS/AUTHORIZATION NUMBERS ARE THE RESPONSIBILITY OF THE
PATIENT OR THEIR RESPONSIBLE PARTY BEFORE THE TIME OF SERVICE.

INSURANCE INFORMATION
(Please present insurance cards at check-in)

Primary Insurance Company _____
Whose Name is Insurance Under? _____ Relation to the Patient _____
SSN# _____ Date of Birth _____
Secondary Insurance Company _____
Whose Name is Insurance Under? _____ Relation to the Patient _____
SSN# _____ Date of Birth _____

I hereby authorize OB/GYN Associates of Shreveport to furnish information concerning my illness and treatments to insurance carriers, other physicians/health care personnel and my spouse. I hereby assign to the physician(s) all payments for medical service rendered to myself or my dependents. I also agree to pay all attorney and collection fees associated with the collection of fees for any services rendered. I understand that I am responsible for any amount incurred.

Signature _____ Date _____

OB/GYN Associates of Shreveport Consent/Authorization

Patient Name _____ Date of Birth _____

Insurance Authorization/Payment Policy

Assignment/Release

I, the undersigned, certify that I (or my dependent) have insurance with the above named insurance company (ies), and assign directly to OB/GYN Associates of Shreveport all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that for medical/legal purposes, and medical records taken/created by this office are the property of OB/GYN Associates of Shreveport. I also understand that all charges for services are due and payable at the time the services are rendered. We accept cash, checks, Mastercard, Visa, Discover and American Express.

Payment Policies

All copays, deductibles, and coinsurance are due at the time of service. If you belong to an HMO, you will need a referral. If you belong to a PPO, you may have a deductible. Remember, it is your responsibility as a patient to get a referral if one is required. If you do not have one, you will be responsible for out-of-network benefits. Please let the receptionist know if you have new insurance at your time of arrival.

Notice to all patients paying by check: If you pay by check and it is returned for any reason from your bank you will automatically be assessed a \$25.00 return check fee.

Medical Records Release and Forms

I understand that if I request a copy of my medical records to be sent to another doctor, I must allow 15 business days for processing from the time I submit a signed authorization. I understand that if I request my medical records to be released to me, I must pre-pay \$25 for in-house records and \$30 for records in storage and allow 15 business days for processing from the time I submit a signed authorization.

I understand if I submit a disability form, Family Medical Leave Act form, or any other form that requires a doctor signature and/or specific information to be completed, I will be charged \$10 and must allow 15 business days for processing.

I, _____ hereby authorize OB/GYN Associates of Shreveport to release any information, in the course of my treatment, necessary to process insurance claims and/or to any other requesting physician in reference to referrals or coordination of care.

Release of Records to a Designated Third-Party

In addition to my treating physicians and medical facilities, I authorize OB/GYN Associates of Shreveport to release and discuss my medical/billing information and records to the following individuals. (This should include **friends or family members responsible for picking up your records when you are unable to do so.**) **PLEASE PRINT**

_____ Relationship: _____

_____ Relationship: _____

Patient Signature

By signing below I am verifying that I have read each of the four sections on this page. I understand each section and consent and agree with the information stated in each section.

Patient/Legal Representative Signature

Legal Representative's Relationship To Patient

Date