

**WELCOME TO OUR OFFICE**

*Please Complete this form and return it to the receptionist. PLEASE PRINT.*

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

PATIENT'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ CELL PHONE \_\_\_\_\_

**IN CASE OF EMERGENCY PLEASE NOTIFY:**

NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

\*\*\*\* IF MARRIED, PLEASE INDICATE SPOUSE'S NAME AND DAYTIME PHONE\*\*\*\*

**RESPONSIBLE PARTY (IF PATIENT IS A MINOR)**

NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE CO. \_\_\_\_\_

POLICY NO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_ CONTRACT \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_ POLICY HOLDER DOB \_\_\_\_\_

POLICY HOLDER'S EMPLOYER \_\_\_\_\_

SECONDARY INSURANCE CO. \_\_\_\_\_

POLICY NO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_ CONTRACT \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_ POLICY HOLDER DOB \_\_\_\_\_

POLICY HOLDER'S EMPLOYER \_\_\_\_\_

\_\_\_\_\_  
DATE SIGNATURE

**RELEASE OF INFORMATION**

I HERBY AUTHORIZE AND ALLOW BROOME OBSTETRICS AND GYNECOLOGY, PC HAVING TREATED ME, TO RELEASE TO GOVERNMENTAL AGENCIES, HOSPITALS, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE, ALL INFORMATION NEEDED FOR MEDICAL TREATMENT, HEALTHCARE OPERATIONS AND TO SUBSTANTIATE PAYMENT FOR SUCH MEDICAL CARE TO PERMIT REPRESENTATIVE THEREOF TO EXAMINNE AND MAKE COPIES OF ALL RECORDS, INCLUDING HIV, RELATING TO SUCH CARE AND TREATMENT.

\_\_\_\_\_  
SIGNATURE OF PATIENT/AUTH REPRESENTATIVE

\_\_\_\_\_  
DATE

**INSURANCE ASSIGNMENT**

I HERBY ASSIGN, TRANSFER AND SET OVER TO BROOME OBSTETRICS AND GYNECOLOGY PC SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY MEDICAL CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT IN SAID MEDICAL GROUP.

\_\_\_\_\_  
SIGNATURE OF PATIENT/AUTH REPRESENTATIVE

\_\_\_\_\_  
DATE

**PRIVACY RELEASE**

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES OF BROOME OBSTETRICS AND GYNECOLOGY, PC.

\_\_\_\_\_  
SIGNATURE OF PATIENT/AUTH REPRESENTATIVE

\_\_\_\_\_  
DATE

**MEDICARE RELEASE**

I CERTIFY THAT THE INFORMATION GIVEN TO ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, OR ITS CARRIERS, ANY INFORMATION REQUIRED TO PROCESS MY MEDICAL CLAIMS. I REQUEST PAYMENT TO BE MADE TO BROOME OBSTETRICS AND GYNECOLOGY, PC.

\_\_\_\_\_  
SIGNATURE OF PATIENT/AUTH REPRESENTATIVE

\_\_\_\_\_  
DATE

**PAYMENT AND/OR CO-PAYS ARE DUE AT THE TIME OF SERVICE**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

**FAMILY HISTORY**

Illness	Relative	Age onset	Illness	Relative	Age onset
Y N Breast Cancer	_____	_____	Y N Ovarian Cancer	_____	_____
Y N Colon Cancer	_____	_____	Y N Other Cancer	_____	_____
Y N Heart Disease	_____	_____	Y N Hypertension	_____	_____
Y N Depression/Anxiety	_____	_____	Y N Stroke	_____	_____
Y N Thyroid Disease	_____	_____	Y N Osteoporosis	_____	_____
Y N Bleeding Disorders	_____	_____	Y N Mental Retardation	_____	_____
Y N Birth Defects	_____	_____	Y N Genetic Disease	_____	_____
Y N Diabetes	_____	_____	Y N Other	_____	_____

**SOCIAL HISTORY**

Tobacco Use Y N How Much \_\_\_\_\_ Number of Years \_\_\_\_\_  
Alcohol Use Y N How Much \_\_\_\_\_  
Recreational Drug Use Y N How Much \_\_\_\_\_ Number of Years \_\_\_\_\_  
Calcium Intake Y N Calcium Supplement Y N \_\_\_\_\_  
Caffeine Intake Y N How Much \_\_\_\_\_  
Exercise Y N How often \_\_\_\_\_ Type \_\_\_\_\_

**MEDICATIONS (INCLUDING OVER THE COUNTER)**

Medication	Medication	Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

See Attached List \_\_\_\_\_

**MENSTRUAL HISTORY**

Age at first menstrual period \_\_\_\_\_  
Cycle length \_\_\_\_\_ Flow length \_\_\_\_\_  
Menstrual flow – Light \_\_\_\_\_ Moderate \_\_\_\_\_ Heavy \_\_\_\_\_

If you have stopped having menstrual periods, at what age did you have your last one \_\_\_\_\_

Date Updated and Reviewed \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
 Referred By \_\_\_\_\_ Physician Address \_\_\_\_\_  
 Specialists \_\_\_\_\_

**ALLERGIES (REACTIONS)** \_\_\_\_\_ (\_\_\_\_\_)  
 \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_)

**MEDICAL HISTORY**

Y N Heart Disease _____	Y N Hypertension _____	Y N High Cholesterol _____
Y N Stroke _____	Y N Bleeding Disorders _____	Y N Mitral Valve Prolapse _____
Y N Asthma _____	Y N Thyroid Disease _____	Y N HIV _____
Y N Osteopenia _____	Y N Osteoporosis _____	Y N Joint Replacement _____
Y N Diabetes _____	Y N Anxiety/Depression _____	Y N Migraines _____
Y N GERD _____	Y N Peptic Ulcer Disease _____	Y N Transfusion HX _____
Y N Cancer _____	Y N Seizures _____	Y N STD Exposure _____

Other \_\_\_\_\_

**FAMILY PLANNING** \_\_\_\_\_

**OPERATIONS/HOSPITALIZATIONS**

Date	Procedure	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**OBSTETRICAL HISTORY** G \_\_\_\_\_ T \_\_\_\_\_ Pt \_\_\_\_\_ A \_\_\_\_\_ L \_\_\_\_\_

Date	Type of Delivery (Complications)	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DEXA Scan Y N Date's \_\_\_\_\_  
 Colonoscopy Y N Date's \_\_\_\_\_  
 Gardasil Vaccine's Y N Date's \_\_\_\_\_

Date Updated and Reviewed \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Medical Doctor: \_\_\_\_\_

Last menstrual period: \_\_\_\_\_ Medications: \_\_\_\_\_

Please check any of the following symptoms that apply to you. Thank You.

<b>CONSTITUTIONAL</b>	<b>YES</b>	<b>NO</b>	<b>MUSCULOSKELETAL</b>	<b>YES</b>	<b>NO</b>
Weight loss	—	—	Muscle weakness	—	—
Weight gain	—	—	Muscle/joint pain	—	—
Change in height	—	—	<b>SKIN</b>		
Fever	—	—	Bruises	—	—
<b>EYES/EARS/NOSE/THROAT</b>			Rash	—	—
Vision changes	—	—	Changes in moles	—	—
Earaches	—	—	<b>BREASTS</b>		
Hearing problems	—	—	Pain in breasts	—	—
Sore throat	—	—	Nipple discharge	—	—
Mouth sores	—	—	Lumps	—	—
<b>CARDIOVASCULAR</b>			<b>NEUROLOGIC</b>		
Chest pain	—	—	Seizures	—	—
Swelling of legs	—	—	Dizziness	—	—
Rapid/irregular heartbeat	—	—	Numbness	—	—
<b>RESPIRATORY</b>			Frequent/severe headaches	—	—
Coughing up blood	—	—	<b>PSYCHIATRIC</b>		
Shortness of breath	—	—	Feeling down/sad	—	—
Chronic cough	—	—	Feeling anxious	—	—
Wheezing	—	—	<b>ENDOCRINE</b>		
<b>GASTROINTESTINAL</b>			Heat/cold intolerance	—	—
Frequent diarrhea	—	—	Abnormal thirst	—	—
Bloody stool	—	—	Hot flashes	—	—
Nausea/vomiting	—	—	Chronic fatigue	—	—
Constipation	—	—	<b>HEMATOLOGIC/LYMPHATIC</b>		
Change in bowel habits	—	—	Cuts that do not stop bleeding	—	—
Abdominal bloating	—	—	Enlarged lymph nodes/glands	—	—
Frequent indigestion	—	—	<b>ALLERGIC/IMMUNOLOGIC</b>		
Hemorrhoidal pain	—	—	Medication allergies?	—	—
<b>URINARY</b>			List: _____		
Blood in urine	—	—	Other allergies?	—	—
Pain with urination	—	—	List: _____		
Strong urgency to urinate	—	—	Do you drink alcohol?	—	—
Frequent urination	—	—	How much? _____		
Incomplete emptying	—	—	Do you smoke?	—	—
Involuntary urine loss	—	—	How much? _____		
Urine loss w/cough/lift	—	—	Do you exercise?	—	—
<b>GYNECOLOGICAL</b>			Would you like information on domestic violence?	—	—
Abnormal bleeding	—	—			
Painful periods	—	—			
Painful intercourse	—	—			
Abnormal vaginal discharge	—	—			
Itching	—	—			
Possible contact with sexually transmitted disease	—	—			
Bleeding with intercourse	—	—			