Birmingham Obstetrics/Gynecology

PATIENT INFORMATION (Please Print)

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

Address _____
Street

_____E-mail_____
City State Zip

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.**

_____Relation to Patient _____DOB_____
Insured's Name (if other than patient)

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, P.C.

NAME_____ **DATE**_____

Birth Date_____

Primary Care Physician _____

Please list ALL medications taken.
***Please include vitamins and over the counter medicines*.**

Reason for today's visit_____

Medication ***If you already have a list of medications, please provide it to the receptionist***	**Dosage**	**Please check one**	
		Taken daily	**Taken as needed**

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	☐	☐	_____
Heart Disease	☐	☐	_____
Hypertension	☐	☐	_____
Cancer	☐	☐	_____
Breast Cancer	☐	☐	_____

Have you ever had any of the following?

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

Other _____

Allergies: _____

_____

Do you use:	Yes	No	Drug Reactions	Immunizations Up to Date?	
Tobacco	☐	☐	_____	Yes	☐
Alcohol	☐	☐	_____	No	☐
Other Drugs	☐	☐	_____	Unknown	☐

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 ☐ F ☐	_____	_____	_____	_____
_____	M ☐ F ☐	_____	_____	_____	_____
_____	M ☐ F ☐	_____	_____	_____	_____
_____	M ☐ F ☐	_____	_____	_____	_____
_____	M ☐ F ☐	_____	_____	_____	_____

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 ☐