

GENESIS OB/GYN, INC.
PATIENT INFORMATION SHEET
(Please Print)

DATE _____ PCP _____
SOCIAL SECURITY # _____ DATE OF BIRTH _____ AGE _____
LAST NAME _____ FIRST NAME _____ MI _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____
OCCUPATION _____
EMPLOYER _____ BUSINESS PHONE _____
MARITAL STATUS: _____ SINGLE _____ MARRIED _____ DIVORCED _____ OTHER _____
STUDENT: _____ FULL-TIME STUDENT _____ PART-TIME STUDENT _____
REFERRED BY: _____

SPOUSE/PARENT INFORMATION:

FULL NAME _____ RELATIONSHIP _____
SOCIAL SECURITY # _____ DATE OF BIRTH : _____ PHONE: _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
OCCUPATION _____
EMPLOYER _____ BUSINESS PHONE _____
IN CASE OF EMERGENCY, PLEASE NOTIFY (other than spouse) RELATIONSHIP _____
NAME _____ PHONE _____

INSURANCE INFORMATION:

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____
ADDRESS _____ ADDRESS _____
SUBSCRIBER'S NAME _____ RELATIONSHIP TO SUBSCRIBER _____
SUBSCRIBER'S S.S. # _____ SUBSCRIBER'S S.S. # _____
SUBSCRIBER'S DATE OF BIRTH _____ SUBSCRIBER'S DATE OF BIRTH _____
EMPLOYER _____ EMPLOYER _____
GROUP # _____ ID # _____ GROUP # _____ ID # _____

**I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS CLAIMS:
ASSIGNMENT AND RELEASE STATEMENT:**

I HEREBY AUTHORIZE THAT MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE UNDERSIGNED PHYSICIAN, AND I AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NON-COVERED SERVICES; AND I AGREE TO PAY FOR ANY AND ALL MEDICAL SERVICES I RECEIVE FROM THE DOCTORS/PROVIDERS OF THIS PRACTICE THAT MY INSURANCE COMPANY REFUSES TO PAY, FOR WHATEVER REASON. THIS OFFICE WILL FILE A CLAIM IN MY BEHALF. HOWEVER, IF MY INSURANCE COMPANY DENIES PAYMENT FOR ANY REASON (e.g. NON-COVERED SERVICES, DOES NOT PAY FOR PREVENTIVE MEDICINE VISITS, MY FAILURE TO SECURE A REFERRAL FROM MY PRIMARY CARE PHYSICIAN) I WILL PAY FOR SAME UPON WRITTEN/VERBAL NOTICE OF THEIR REFUSAL; AND IN THE EVENT I DO NOT PAY FOR THESE OR ANY OTHER SERVICES PROVIDED ME WHEN DUE, I AGREE TO PAY ALL COSTS OF COLLECTION.

CONSENT TO TREATMENT:

I HEREBY AUTHORIZE MEMBERS OF GENESIS OB/GYN, INC. HEALTHCARE TEAM TO PROVIDE TREATMENT AS NECESSARY.

SIGNATURE _____ DATE _____

GYNECOLOGIC HEALTH HISTORY QUESTIONNAIRE

Name _____
 Race _____ Marital Status: M S D W
 Primary Care Physician _____

Today's Date _____
 Date of Birth _____ Age _____

PAST HEALTH HISTORIES

Please mark with an (X) any of the following illnesses and medical problems you have or have had and indicate the year when started. If you are not certain when an illness started, write down an approximate year.

<u>Illness</u>	<u>(X)</u>	<u>(Year)</u>	<u>Illness</u>	<u>(X)</u>	<u>(Year)</u>	<u>Illness</u>	<u>(X)</u>	<u>(Year)</u>
Glaucoma	___	___	GI Problems	___	___	Convulsions/ Seizures	___	___
Thyroid Problems	___	___	Diverticulosis	___	___	Cancer	___	___
Lung Problems	___	___	Colitis	___	___	Anemia	___	___
Asthma	___	___	Hepatitis	___	___	Diabetes	___	___
High Blood Pressure	___	___	Liver Problems	___	___	Osteopenia/ Osteoporosis	___	___
Heart Attack	___	___	Breast Problems	___	___	Other Medical Illness	___	___
Heart Murmur	___	___	Kidney or Bladder Disease	___	___	Depression	___	___
Rheumatic Fever	___	___	Phlebitis/Varicose Veins	___	___	Psychological Disorders	___	___
Mitral Valve Prolapse	___	___						
Other Heart Problems	___	___						

Please list all times you have been hospitalized, operated on, or seriously injured.

<u>Year</u>	<u>Operation, Illness, Injury</u>	<u>Hospital and City</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Have any blood relatives had any of the following illnesses? If so, indicate relationship.

<u>Illness</u>	<u>Family Members</u>
High blood pressure	_____
Heart disease	_____
Stroke	_____
Cancer, including breast, ovarian, and uterine, other please specify	_____
Diabetes	_____
Clotting disorders	_____
Other	_____

Current Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Are you allergic to any medications?

1. _____
2. _____
3. _____

Do you smoke? Yes No Currently packs per day X yrs.
 Previously smoked packs per day X yrs.
 Alcohol consumption? Yes No Types preferred _____
 Amount: Daily _____ Weekly _____ Monthly _____
 When was the last time you used street drugs? _____; Never _____
 Have you ever been treated for drug, alcohol, or psychological disorders? Yes No
 Specify _____

MENSTRUATION HISTORY

Date of last menstrual period _____
 Are your periods regular? Yes No ; approximately every _____ day X _____ days flow.
 Are your periods painful? Yes No
 Are your periods heavy? Yes No
 What age did your periods begin? _____
 Do you have any pain between periods? Yes No
 Have you ever had an abnormal pap smear? Yes No ; If yes, specify _____
 When was your last pap smear? _____
 Have you ever been sexually abused or assaulted? Yes No
 Do you have any unusual vaginal discharge or burning? Yes No
 Do you feel tense before your periods? Yes No

QUESTIONS REGARDING SEXUAL ACTIVITY

Are you sexually active? Yes No Number of lifetime partners _____
 Do you have pain with intercourse? Yes No
 Have you had more than one partner in the last six months? Yes No
 Have you had a sexually transmitted disease?
 Condylomata (venereal warts) Yes No
 Chlamydia Yes No
 Genital herpes Yes No
 Other venereal disease Yes No
 Do you have any questions or problems concerning sex? Yes No

QUESTIONS REGARDING BIRTH CONTROL

What type of birth control do you use? _____
 If you are taking oral contraceptives, type _____
 Does your partner have a vasectomy? Yes No
 Do you have any questions regarding birth control options? Yes No

QUESTIONS REGARDING MENOPAUSE IF APPLICABLE

Have your periods become irregular? Yes No
 Have you gone longer than one year without a period? Yes No
 Do you have hot flashes? Yes No
 Have you ever taken estrogen replacement therapy? Yes No
 Are you interested in information regarding hormone replacement therapy? Yes No

QUESTIONS REGARDING BREASTS

Do you know how to do a self-breast exam? Yes No
 Do you examine your breasts monthly? Yes No Last Mammogram _____
 Have you ever been diagnosed with fibrocystic breast disease? Yes No Bone Mineral Density
 Have you ever had a breast biopsy? Yes No Results _____
 Does anyone in your family have breast cancer? Yes No
 Do you have any breast discharge? Yes No
 Do you have breast tenderness? Yes No Colonoscopy _____
 Do you have any breast lumps? Yes No

PREGNANCY HISTORY IF APPLICABLE

Have you ever been pregnant? Yes No
 Have you ever had a miscarriage? Yes No Date: _____
 Have you ever had an abortion? Yes No Date: _____
 Any complications? _____
 Living children _____; Premature births _____; Stillbirth _____
 Any complications with pregnancy? Yes No ; Date _____

DELIVERIES

NO	BORN MONTH/YEAR	WEIGHT AT BIRTH	SEX	LENGTH OF PREGNANCY	DELIVERY TYPE	COMPLICATIONS DESCRIBE - IF ANY
1						
2						
3						
4						

GENESIS OB/GYN, INC.

**PATIENT CONSENT FOR USE
DISCLOSURE OF HEALTH INFORMATION**

With my consent, Genesis Ob/Gyn, Inc. may use and disclose health information about me to carry our treatment, payment and health care operations. Please refer to Genesis' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Genesis Ob/Gyn, Inc. reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Genesis Ob/Gyn, Inc. Privacy Officer at 12255 DePaul Drive, Suite 360, Bridgeton, Missouri 63044.

With my consent, Genesis Ob/Gyn, Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory test results among others.

With my consent, Genesis Ob/Gyn, Inc. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminder cards, test results and patient billing/insurance statements as long as they are marked Personal and Confidential.

I have the right to request that Genesis Ob/Gyn, Inc. restrict how it uses or disclosed my health information to carry out treatment, payment or healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Genesis Ob/Gyn, Inc.'s use and disclosure of my health information to carry out treatment, payment or healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Genesis Ob/Gyn, Inc. may decline to provide treatment to me.

Date: _____

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

I have received a copy of Genesis Ob/Gyn, Inc.'s Notice of Privacy Practices.

Date: _____

Signature of Patient