



PATIENT INFORMATION

Patient Name: _____
Last First Middle Initial

Maiden Name: _____ Preferred/Nickname: _____

Date of Birth: ____/____/____ Age: _____ Social Security#: _____ - _____ - _____

Marital Status: _____ Spouse Name: _____ Date of Birth: ____/____/____

Address: _____
Address City/Zip County

Home Phone: _____ Cell Phone: _____

Email address: _____

Race: ____ American Indian/Alaska Native ____ Asian ____ Black/African American ____ Nat Hawaiian/Pacific Islander
____ White ____ Other Ethnicity: ____ Declined ____ Hispanic/Latino ____ Not Hispanic/Latino

Patient Employer: _____

Address: _____
Address City/Zip

Phone: _____ ext _____

Position: _____ Status: _____ Full-time _____ Part-time

Spouse Employer: _____

Address: _____
Address City/Zip

Phone: _____ ext _____

EMERGENCY CONTACT (other than spouse): _____ Relationship

Home/Work Phone: _____ Cell Phone: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Location: _____

Phone: _____ Fax: _____

PHONE MESSAGES

Messages can be left on:	Home phone	_____yes	_____no
	Work phone	_____yes	_____no
	Cell phone	_____yes	_____no

INSURANCE INFORMATION

PRIMARY Insurance Company: _____

Insured Name: _____ Date of Birth: _____

Policy/ID Number: _____ Group#: _____

Relationship to Patient: _____ Effective date of coverage: _____

Does your insurance policy have Wellness Benefits? _____ YES _____ NO

SECONDARY Insurance Company: _____

Insured Name: _____ Date of Birth: _____

Policy/ID Number: _____ Group#: _____

Relationship to Patient: _____ Effective date of coverage: _____

Does your insurance policy have Wellness Benefits? _____ YES _____ NO

How did you hear about our office? _____ Referred by: _____

I give my permission to Madison OB/GYN Associates, LLC to administer treatment and perform necessary minor operative procedures in diagnosing and or treating my condition. I authorize the release of any medical information necessary to process a claim on any insurance policy listed above. I hereby assign to and authorize payment directly to this Clinic, of all benefits payable under such insurance policy. I realize that my insurance may not pay in full, and I understand that I am responsible for my co-payment, co-insurance, and deductible at the time services are rendered. I agree to be personally and fully responsible for payment. In case of default, I will be responsible for all costs incurred in the collection of this and future outstanding balances.

Signature of Patient or Responsible Party

Date



Patient Name: _____ Date of Birth: _____

Drug Allergies: _____ Penicillin _____ Sulfa _____ Other _____

MEDICATIONS

Drug Name	Dosage	Prescribing Physician

Reason for visit today: _____

Medical History: _____

Surgical History: _____

PERSONAL MEDICAL HISTORY

Total pregnancies _____ Living children _____ Miscarriages _____ Abortions _____

Full term _____ Preterm _____ Tubal pregnancies _____

Check if you have ever had: Chlamydia _____ Gonorrhea _____ Herpes _____ HIV _____ Syphilis _____

Have you ever been tested for HIV? No _____ Yes _____ Date tested _____ Results _____

Have you ever had a blood transfusion? No _____ Yes _____ Date _____



Patient Name: _____ Date of Birth: _____

MENSTRUAL HISTORY

Age of onset: _____ Frequency: every _____ days Duration of flow: _____ days

Flow: _____ Light _____ Medium _____ Heavy Cramps: _____ None _____ Mild _____ Moderate _____ Severe

Irregular Bleeding: _____ Yes _____ No Clots: _____ Yes _____ No

History of abnormal pap smears: _____ Yes _____ No Treatment required: _____ Yes _____ No

Date of last period: _____ Birth control method: _____

Age of menopause: _____ Currently on hormones: _____ Yes _____ No

Previous Hospitalizations: _____

SOCIAL HISTORY

Alcohol use? _____ Yes _____ No Drinks per day _____ Drinks per week _____

Illegal Drug use? _____ Yes _____ No Type _____

Do you smoke? _____ Yes _____ No Packs per day _____

Do you exercise? _____ Yes _____ No How often? _____

FAMILY HISTORY

Please list the family member who has or had the following:

Breast cancer _____ Osteoporosis _____

Colon cancer _____ Ovarian cancer _____

Diabetes _____ Stroke _____

Heart disease _____ Thyroid disease _____

High blood pressure _____ Gynecologic cancer _____

Kidney disease _____ Other _____

Genetic or inherited disorders _____