

PATIENT INFORMATION SHEET

PATIENT'S

NAME: _____
LAST FIRST MI MARITAL STATUS

SS NUMBER: _____ DOB: _____ HOME PHONE#: _____

ADDRESS: _____
STREET NO. & NAME CITY STATE ZIP CODE

EMPLOYER: _____ WORK PHONE # _____

SPOUSE'S NAME: _____ SS# _____ DOB _____

SPOUSE'S EMPLOYER: _____ WORK PHONE # _____

EMERGENCY CONTACT: _____ RELATIONSHIP _____ DAYTIME PHONE# _____

REFERRED BY: _____ PCP _____ NAME / PHONE # _____

INSURANCE
Does your insurance allow a routine GYN exam (Well Woman)? Y or N

Do you have a Primary Care Physician? Y or N Does your insurance require a referral? Y or N

Primary Insurance: _____
Name Address Phone #

Policy Holder: _____ DOB: _____ SS#: _____

Policy or ID#: _____ Group #: _____

Secondary Insurance: _____
Name Address Phone #

Policy Holder: _____ DOB: _____ SS#: _____

Policy or ID#: _____ Group#: _____

I acknowledge that payment be made directly to the physician for any medical services received.
Signature X _____ Date _____

I hereby authorize the physician to release any information acquired during the course of my examination/treatment to any lab, physician, hospital, or pharmacy involved with my continuity of care.
Signature X _____ Date _____

I authorize the transmission of my medical records by fax if the necessity should arise without additional written request.
Signature X _____ Date _____

I give authorization to the physician and/or staff to leave medical information including appointment info and/or results on my answering machine at home and/or work or with individual noted: _____
Signature X _____ Date _____

I understand the above authorizations are effective from the date noted above until further notice unless a written request is received by the physician. _____
INITIAL

PLEASE CHECK IF YOU HAVE EVER HAD THE FOLLOWING PROBLEMS:

Any skin rashes:

- Bumps
- Itching
- Dryness
- Color change in hair/nails
- Chicken pox

Any head injury:

- Frequent or severe
- Headaches

Any eye disease:

- Injury
- Impaired sight

Any ear disease:

- Injury
- Impaired hearing

Any problem with nose:

- Mouth
- Sinuses
- Throat
- Neck

Any breast problems:

- Lumps
- Nipple discharge
- Pain
- Tenderness

Any chest problems such as:

- Chronic coughing
- Asthma
- Wheezing
- Emphysema
- Pneumonia
- Spitting of blood
- Pain
- Shortness of breath

Any heart trouble:

- High blood pressure
- Rheumatic fever
- Heart murmurs
- Chest pain
- Palpitations
- Swelling
- Past EKG or other heart test

Any trouble swallowing:

- Indigestion
- Constipation
- Diarrhea
- Change in bowel habits
- Rectal bleeding
- Black stools
- Hemorrhoids
- Liver or gall bladder trouble
- Hepatitis

Any urinary trouble:

- Frequent urination
- Painful urination
- Leaking of urine when cough/sneeze

Bladder/Kidney:

- Infections
- Stones

Any joint pain:

- Arthritis
- Backache
- Muscle pains/cramps
- Varicose veins
- Blood cells
- Inflammation in veins

Any thyroid trouble:

- Heat/cold intolerance
- Excessive sweating
- Excessive thirst
- Excessive hunger
- Excessive urination
- Diabetes

Any nervousness:

- Tension
- Moodiness
- Depression
- Anxiety

Any trouble with fainting:

- Blackouts
- Seizures
- Local weakness
- Numbness
- Tingling
- Tremors
- Memory loss

Any problems with:

- Anemia
- Easy bruising
- Bleeding
- Blood transfusions

when _____
Any problems with swelling
of lymph nodes _____

OTHER _____

GYNECOLOGIC HISTORY:

Age at onset of menses _____ Are they regular? _____ Cycle _____ days (from start to start) How long do they last? _____

Flow _____ light _____ moderate _____ heavy _____ Do you have pain or cramps? _____ Date of last period? _____

Are you taking birth control pills now? _____ If yes, what? _____ Do you have side effects from birth control pills? _____

Please check any of the following birth control methods you have used: _____ condoms _____ foam _____ Depo Provera injections
_____ diaphragm _____ IUD _____ tubal ligation _____ vasectomy _____ OTHER _____

Date of last Pap smear _____ Was it normal? _____ Do you have any history of abnormal Pap smears? _____

History and/or treatment of infertility? _____ Number of Pregnancies _____ miscarriages _____ deliveries _____ living _____

Have you had any of the following sexually transmitted diseases? _____ herpes _____ chlamydia _____ gonorrhoea _____ AIDS
_____ syphilis _____ genital warts.

Have you had any of the following? _____ vaginal infection _____ discharge _____ itching

Have you had any of the following symptoms of menopause? _____ night sweats _____ hot flashes _____ irritability
_____ heart palpitations _____ vaginal dryness _____ irregular menses

If postmenopausal, do you ever experience any vaginal bleeding? _____

PATIENT'S SIGNATURE _____ DATE _____

PHYSICIAN'S SIGNATURE _____ DATE REVIEWED: _____

PHYSICIAN'S SIGNATURE _____ DATE REVIEWED: _____

PHYSICIAN'S SIGNATURE _____ DATE REVIEWED: _____

**BARBARA NYLANDER, MD / CARL E. WINGO, MD / JACKSON COTHREN, MD
SALLY YEAGLEY, NP AND ANNE MOORE, NP
FINANCIAL POLICY**

1. All charges incurred for services in the office will be payable at the time of service unless other arrangements are made.
2. All co-payments are due prior to service being provided.
3. There will be a \$25.00 service charge on all returned checks.
4. The deductible and co-pay may be required in advance for all surgeries. All elective procedures, not covered by insurance must be paid in full prior to the surgery unless other arrangements are made.
5. All OB patients are required to pay any portion of the delivery fee not covered by the end of the seventh month. OB patients are also required to promptly pay for any other services provided during the pregnancy. Care may be discontinued at any time for non-compliance.
6. All contraceptive devices furnished at the office are to be paid at the time service is provided unless prior arrangements made or prior approval from your insurance is received.
7. Patients needing services due to an injury which involves a third party will be responsible for their own account. As a courtesy, we will be glad to file insurance for you.
8. The responsibility for payment of service lies with the person seeking treatment or the person seeking treatment for another. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.
9. All patients seeking infertility services, not covered by insurance must be paid at the time of service.
10. All patients having insurance requiring a referral for OB/GYN services will be required to present the referral before services are provided. Any patient seeking services without a referral must pay for the service in advance or reschedule the appointment.
11. The physicians may discontinue care for any patient due to non-payment or non-compliance.
12. Any patient's account that cannot be collected by our office will be turned over to a collection agency. In this event, payment in full will be required for any future services regardless of insurance coverage. In the event of default, you agree to pay any court costs, attorney fees, cost of collection, and any contingent fees to collection agencies of not less than 35%. Such contingency fee is to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.

Patient/Guarantor Signature

Date