

## BILTMORE OB-GYN

DATE	NEW PATIENT INFORMATION								
PATIENT'S NAME (PLEASE PRINT)	SS#	MARITAL STATUS				SEX		BIRTHDATE	AGE
		S	M	W	D	SEP	M		
STREET ADDRESS <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY	CITY AND STATE				ZIP CODE		HOME PHONE #		
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)				HOW LONG EMPLOYED		CELL PHONE#		
EMPLOYER'S STREET ADDRESS	CITY AND STATE				ZIP CODE		BUS. PHONE # EXT.#		
EMERGENCY CONTACT PERSON							PHONE#		
SPOUSE OR PARENT'S NAME	SS#				BIRTHDATE				
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)				HOW LONG EMPLOYED		BUS. PHONE #		
EMPLOYER'S STREET ADDRESS	CITY AND STATE				ZIP CODE		CELL PHONE #		
SPOUSE'S STREET ADDRESS, IF DIVORCED OR SEPARATED	CITY AND STATE				ZIP CODE		HOME PHONE #		

**PLEASE ATTACH YOUR CURRENT INSURANCE CARD(S) AND DRIVER'S LICENSE SO WE MAY DUPLICATE THEM FOR OUR RECORDS (THIS ASSISTS US AND YOUR INSURANCE COMPANIES).**

### INSURANCE AUTHORIZATION AND ASSIGNMENT

GENERAL INSURANCE COMPANY (NOT MEDICARE) \_\_\_\_\_

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

NAME OF POLICYHOLDER \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE COMPANY BENEFITS BE MADE ON MY BEHALF TO BILTMORE OB-GYN FOR ANY SERVICES RENDERED. I UNDERSTAND I AM RESPONSIBLE FOR THE DEDUCTIBLE, COINSURANCE AND NON COVERED SERVICES. I UNDERSTAND THIS AUTHORIZES RELEASE OF MEDICAL RECORDS AND INFORMATION TO PAY CLAIM.

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

PATIENT \_\_\_\_\_

IF NOT SIGNING, GIVE RELATIONSHIP TO PATIENT \_\_\_\_\_

MEDICARE SIGNATURE ON FILE \_\_\_\_\_

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THE AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS MEDICARE ASSIGNMENT. I UNDERSTAND THAT IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR ANY TREATMENT. (SECTION 1128B OF THE SOCIAL SECURITY ACT AND 31 U.S.C. 2801-3812 PROVIDES PENALTIES FOR WITHHOLDING THIS INFORMATION). REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS ALSO APPLY.

PATIENT'S SIGNATURE \_\_\_\_\_ POLICY # \_\_\_\_\_ DATE \_\_\_\_\_

### MEDIGAP AUTHORIZATION STATEMENT

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO \_\_\_\_\_ ANY INFORMATION NEEDED FOR THIS OR RELATED MEDIGAP CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

PATIENT'S SIGNATURE \_\_\_\_\_ POLICY # \_\_\_\_\_ DATE \_\_\_\_\_

**BILTMORE OB-GYN  
MEDICAL HISTORY**

<b>NAME:</b> _____	<b>DATE:</b> _____	
REFERRING PHYSICIAN _____		ALLERGIES TO MEDICATIONS _____
PLEASE INDICATE REASON FOR THIS OFFICE VISIT _____		CURRENT MEDICATIONS / HORMONES / VITAMINS / HERBS _____
MARRIED / DIVORCED / SEPARATED / SINGLE _____		
OCCUPATION _____		<b>MEDICAL HISTORY</b>
DO YOU LIVE ALONE? _____		DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING?
<b>GYNECOLOGICAL HISTORY</b>		BLOOD TRANSFUSIONS _____
AGE PERIODS BEGAN _____		HEART DISEASE / MURMUR _____
LAST MENSTRUAL PERIOD _____		HIGH BLOOD PRESSURE _____
# DAYS PERIOD LAST _____		STROKE _____
# DAYS BETWEEN PERIODS _____		EPILEPSY / SEIZURES _____
PRESENT METHOD OF BIRTH CONTROL _____		MIGRAINES _____
LAST PAP SMEAR (DATE) _____ RESULT _____		DEPRESSION / PSYCHOLOGICAL ILLNESS _____
		ASTHMA _____
<b>DO YOU HAVE A HISTORY OF: (INCLUDE DATES)</b>		PULMONARY EMBOLISM _____
ABNORMAL PAP SMEAR _____		OTHER LUNG DISEASE _____
COLPOSCOPY / CRYOSURGERY / LASER SURGERY _____		PHLEBITIS / DVT _____
GENITAL WARTS / HERPES / CHLAMYDIA / GONORRHEA _____		KIDNEY STONES OR OTHER DISEASE _____
NIGHT SWEATS / HOT FLASHES / VAGINAL DRYNESS (CIRCLE IF APPLIES) _____		THYROID DISEASE _____
LEAKING OF URINE _____		DIABETES _____
PELVIC INFLAMMATORY DISEASE _____		HEPATITIS / LIVER DISEASE _____
INFERTILITY _____		GALLBLADDER DISEASE _____
ENDOMETRIOSIS _____		ANOREXIA / BULIMIA / EATING DISORDER _____
DES EXPOSURE _____		ANEMIA / BLOOD DISORDER _____
INFREQUENT OR IRREGULAR PERIODS _____		CANCER _____
OVARIAN CYSTS _____		COLLAGEN VASCULAR DISEASE / LUPUS _____
OVARIAN CANCER _____		ARTHRITIS _____
UTERINE CANCER _____		FIBROMYALGIA _____
FIBROIDS _____		CHRONIC FATIGUE _____
BREAST DISEASE _____		OSTEOPOROSIS _____
BREAST SURGERY _____		URINARY PROBLEMS _____
BREAST D/C _____		BOWEL PROBLEMS _____
DATE OF LAST MAMMOGRAM _____		GLAUCOMA _____
MAMMOGRAM RESULT _____		LAST CHOLESTEROL TEST (DATE / RESULT) _____
		LAST FASTING BLOOD SUGAR (DATE / RESULT) _____
<b>PREGNANCY HISTORY</b>		LAST SIGMOIDOSCOPY (DATE / RESULT) _____
NUMBER OF ELECTIVE ABORTIONS _____		LAST BONE DENSITY (DATE / RESULT) _____
NUMBER OF MISCARRIAGES _____		LAST IMMUNIZATION FOR TETANUS _____
NUMBER OF CHILDREN _____		HAVE YOU BEEN IMMUNIZED FOR HEPATITIS B? YES NO _____
NUMBER OF VAGINAL DELIVERIES _____		HAVE YOU BEEN IMMUNIZED FOR PNEUMOCOCCAL? YES NO _____
NUMBER OF C SECTIONS _____		
COMPLICATIONS _____		CAFFEINE (CUPS OF COFFEE, TEA, SODA / DAY) _____
		CURRENT NUMBER CIGARETTES PER DAY _____
<b>PAST SURGICAL HISTORY / HOSPITALIZATIONS</b>		PAST CIGARETTE USE (# OF YEARS) _____
YEAR(S), PROCEDURES(S) _____		CURRENT AND PAST ALCOHOL INTAKE _____
		STREET DRUG USE? YES NO _____
<b>FAMILY HISTORY</b>		EXERCISE? YES NO _____
BREAST CANCER _____	STROKE _____	EXERCISE (FREQUENCY) _____
OVARIAN CANCER _____	HIGH CHOLESTEROL _____	EXERCISE (DURATION) _____
UTERINE CANCER _____	OSTEOPOROSIS _____	DO YOU PERFORM SELF BREAST EXAMS? (YES / NO) _____
COLON CANCER _____	BLOOD CLOTS _____	SUN EXPOSURE? _____
DIABETES _____	ALZHEIMERS _____	SPF # _____
HIGH BLOOD PRESSURE _____	THYROID DISEASE _____	
HEART ATTACK / HEART DISEASE _____	OTHER _____	
<b>PATIENT NAME</b> _____	<b>CHART #</b> _____	<b>DOB</b> _____
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