BILTMORE OB-GYN

DATE	PATIENT INFORMATION							
PATIENTS NAME (PLEASE PRINT)	SS#	MARITAL STATUS: S / M / W / D / SEP		SEX: M / F		BIRTHDATE		AGE
STREET ADDRESS ❑ PERMANENT ❑ 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

NAME:____________________________________**DATE:**___________	
REFERRING PHYSICIAN	ALLERGIES TO MEDICATIONS
PLEASE INDICATE REASON FOR THIS OFFICE VISIT	
	CURRENT MEDICATIONS / HORMONES / VITAMINS / HERBS
MARRIED / PARTNERED/ DIVORCED / SEPARATED / SINGLE	
OCCUPATION	**MEDICAL HISTORY**
DO YOU LIVE ALONE?	DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF
	THE FOLLOWING?
GYNECOLOGICAL HISTORY	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
DO YOU HAVE A HISTORY OF: (INCLUDE DATES)	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	THYROID DISEASE
(CIRCLE IF APPLIES)	DIABETES
LEAKING OF URINE	HEPATITIS / LIVER DISEASE
PELVIC INFLAMMATORY DISEASE	GALLBLADDER DISEASE
INFERTILITY	ANOREXIA / BULIMIA / EATING DISORDER
ENDOMETRIOSIS	ANEMIA / BLOOD DISORDER
DES EXPOSURE	CANCER
INFREQUENT OR IRREGULAR PERIODS	COLLAGEN VASCULAR DISEASE / LUPUS
OVARIAN CYSTS	ARTHRITIS
OVARIAN CANCER	FIBROMYALGIA
UTERINE CANCER	CHRONIC FATIGUE
FIBROIDS	OSTEOPOROSIS
BREAST DISEASE	URINARY PROBLEMS
BREAST SURGERY	BOWEL PROBLEMS
BREAST D/C	GLAUCOMA
DATE OF LAST MAMMOGRAM	
MAMMOGRAM RESULT	LAST CHOLESTEROL TEST (DATE / RESULT)
	LAST FASTING BLOOD SUGAR (DATE / RESULT)
PREGNANCY HISTORY	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
PAST SURGICAL HISTORY / HOSPITALIZATIONS	PAST CIGARETTE USE (# OF YEARS)
YEAR(S), PROCEDURES(S)	CURRENT AND PAST ALCOHOL INTAKE
	STREET DRUG USE? YES___ NO___
FAMILY HISTORY	EXERCISE? YES NO
BREAST CANCER STROKE	EXERCISE (FREQUENCY)
OVARIAN CANCER HIGH CHOLESTEROL	EXERCISE (DURATOIN)
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	

PATIENT NAME____________________________**CHART #**__________**DOB**_____________