MORNING STAR OB/GYN

3011 S. LINDSAY ROAD, STE 113, GILBERT, AZ 85296, Tel: 480-355-8525 Fax: 480-355-3115

PATIENT INFORMATION

Patient Name: ______________________________

Appointment Date: __________ **Time:** __________ **Provider:** ______________________

Mailing Address: ______________________________ **Apt/Ste**: ______

City, State & ZIP: ______________________________

Street Address (if different than mailing): ______________________________

Home Phone: ____________ **Can we leave a message at home? (please circle)** Y N

Cell Phone: ____________ **Can we leave a message on cell phone? (please circle)** Y N

Employer Name: ______________ **Address:** ______________________

Work Phone: ____________ **Can we leave a message at work? (please circle)** Y N

Date of Birth: ____________ **Marital Status:** ______________________

Social Security Number: ______________________________

Primary Care Physician: ______________________ **Phone:** ____________

Address: ______________________________

Emergency Contact Name: __________________ **Relationship:** ______________

Phone Number: ______________________________

Pharmacy Name: ________________ **Phone:** ____________ **Fax:** ____________

Address (cross streets & city are sufficient): ______________________

PAYMENT INFORMATION

Guarantor Name: ________________ **Relationship to Patient:** ______________

Address: ______________________________

Gender: (please circle) M F **Social Security Number:** __________ **Date of Birth:** __________

Guarantor's Employer Name: ______________ **Work Phone:** ______________

Work Address: ______________________________

Primary Insurance: ______________________________

Address: ______________________ **Insured Relationship to Pt:** ________

Insured Name: ______________________ **Date Of Birth:** ____________

Subscriber ID: ____________ **Group Number:** ______________

Secondary Insurance: ______________________________

Address: ______________________ **Insured Relationship to Pt:** ________

Insured Name: ______________________ **Date Of Birth:** ____________

Subscriber ID: ____________ **Group Number:** ______________

Medigap? ________ **Supplemental?** ________

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Morning Star OB/GYN for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. **I understand that co-pays, co-insurance, deductibles and non-covered services are due at the time of service.**

Signature of Responsible Party: ______________________________ Date: ____________

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: ______________________________ Date: ____________

MEDICAL INFORMATION

What is the reason for your visit today? ______________________________

Do you have any other special concerns you would like the doctor to address? ______________________________

____

Medications

Please list all medications and supplements you are taking and the dosages: ______________________________

____

____

____

Allergies

Please list any allergies to medicine or food: ______________________________

____

____

Medical History Update

Since your last visit, are there any updates to your medical history, including diagnosis, hospitalizations, surgeries, etc? (please circle) Y N

If yes, please include dates of occurrence: ______________________________

____

____

____

____

Gynecology History

What was the first day of your last period? __________

Are you using a family planning method? (please circle) Y N

If so, please select the method(s) you currently use:

___ Symptothermal (chart temperature and watch cervical mucus signs and symptoms)

___ Ovulation Method (chart mucus signs and symptoms only)

___ Calendar/rhythm (count days or use calendar)

___ Birth Control Pills

___ Condoms

___ IUD (Intrauterine Device) please circle: copper hormonal

___ Withdrawal

___ Tubal Ligation

___ Vasectomy

___ Other____________________________________

How many sexual partners have you had in the last 12 months? ___________

Review of Systems

Please check those problems which apply to you:

GENERAL

Fatigue ____

Weight gain ____

Weight loss ____

Fever ____

Hot flashes ____

ENDOCRINE

Sensitivity to hot _____

Sensitivity to cold ____

Excessive thirst ____

Abnormal hair growth ____

Hair loss ____

NEURO

Headaches _____

Seizures ____

Loss of strength ____

Loss of sensation ____

SKIN

Rash _____

Moles (growth/change) _____

Acne _____

EYES

Visual changes _____

Seeing spots or lights_____

ENT

Sore Throat ____

Nasal congestion ____

RESPIRATORY

Cough ____

Difficulty breathing ____

HEART

Chest pain ____

Palpitations ____

BREASTS

Breastfeeding ____

Mass or lump ____

Nipple discharge ____

Breast tenderness ____

Perform self breast exam ____

Other _________________________

GASTROINTESTINAL

Abdominal pain ____

Nausea ____

Vomiting ____

Diarrhea ____

Constipation ____

Heartburn ____

Blood in stool ____

GYN

Vaginal discharge ____

Vaginal burning/pain ____

Vaginal bulge ____

Vaginal/vulvar itching ____

Pelvic pain/pressure ____

Abnormal bleeding ____

Other _________________________

UROLOGY

Painful/burning urination ____

Blood in urine ____

Leakage or loss of urine ____

MUSCULOSKELETAL

Muscle pain ____

Joint pain ____

Joint swelling ____

MOOD

Depressed ____

Anxiety ____

Mood swings ____

HEMATOLOGY

Easy bruising ____

Frequent nosebleeds ____

This information is correct and has been completed to the best of my knowledge.

____ ______________________

Patient Signature Date