MORNING STAR OB/GYN

3499 S. MERCY ROAD, GILBERT, AZ 85297, Tel: 480-355-8525 Fax: 480-355-3115

PATIENT INFORMATION

Patient Name: ______________________ **Marital Status:** ________

Date of Birth: _____ **Appointment Date:** _____ **Time:** _____ **Provider:** _______

Mailing Address: ______________________ **Apt/Ste:** ________

City, State & ZIP: ______________________ **Email address:** ________

Street Address (if different than mailing): ______________________ **SSN:** ________

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

Please rank as 1st, 2nd, 3rd, and 4th; your preference for our communications with you in the future.

____ **Text Message** ____ **Secure Web Portal** ____ **E-Mail** ____ **Phone Call**

I consent to receive calls, text messages, or emails from Morning Star OB/GYN for my protected healthcare and other services at the phone number(s) listed above, as indicated by circling the Y. I understand that such calls may be generated by an automated dialing system and that such calls to my cell phone may result in charges by my wireless carrier. I realize that consent is not required as a condition of being a patient and that I may revoke this authorization at any time and that the revocation does not have to be in writing.

Signature of Responsible Party: ______________________ Date: ________

What is your race? (please circle) American Indian or Alaskan Native Asian Native Hawaiian or other Pacific Islander

Black or African American White Hispanic Other ________ Other Pacific Islander Decline To Answer

What is your ethnicity? Hispanic or Latino Non-Hispanic or Latino Decline to Answer

Preferred Language? ______________

Pharmacy Name: ________ **City:** ________ **Phone Number:** ________

Address or cross streets: ______________________

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

Phone Number: ______________________

Primary Care Physician: ______________ **Phone:** ______________

Address: ______________________

Employer Name: ______________ **Address:** ______________

Work Phone: ________ **Can we leave a message at your work?** Y N

How did you hear about us? ______________________

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:** ________

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. I also understand that any lab services such as blood work, cultures, and Pap smears are additional charges dependent on and invoiced by the lab vendor.**

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

Last Name ________________, First Name _______________