Patient Information

PATIENT INFORMATION			
Patient name *(last, first, M.I.):*			**Date of Birth:**
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed			
Home Phone:	**Cell Phone:**		**Social Sec. #:**
Email:			
Mailing Address:			
Employer:			
Emergency Contact: *(name, relationship)*		**Emergency Contact Phone:**	

RELEASE OF MEDICAL INFORMATION	
Voicemail Preference	☐ Leave message with detailed information ☐ Leave call back number only
Written Communication	☐ Email Address ☐ Mailing Address
Normal Test Results	☐ Home ☐ Cell ☐ Email ☐ Mail ☐ Authorized Person:
Abnormal Test Results	☐ Home ☐ Cell ☐ Email ☐ Mail ☐ Authorized Person:

INSURANCE INFORMATION			
Primary Insurance		Secondary Insurance	
Policy #		Policy #	
Group #		Group #	
Claims Address:		Claims Address:	
City, State, Zip:		City, State, Zip:	
Policy Holder Name:		Policy Holder Name:	
Policy Holder DOB:		Policy Holder DOB:	
Policy Holder SSN:		Policy Holder SSN:	

ASSIGNMENT OF INSURANCE BENEFITS / CONSENT FOR TREATMENT

I, the undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on my behalf or dependent's. I further agree and acknowledge that my signature on this document authorizes my physician to submit all claims for benefits for services rendered without obtaining my signature on each and every claim and that these claims may be paid directly to her. Also, I hereby grant Dr. Brooks and her medical staff to perform such medical procedures as discussed with me as deemed necessary. If the above patient is a minor, I am granting permission for treatment and I am an authorized person to do so. I have also received a copy of the "Notice of Privacy Practice" upon request and if I have any questions, I may discuss them with the staff. I also understand the financial policy to be:

1. Payment is due at the time of service and a $5-statement fee will be added to unpaid accounts. Returned checks will incur a $25- service fee.
2. A $50 cancellation fee will apply to appointments cancelled less than 24 hours in advance.
3. Accounts past 45 days are patient's responsibility per state law. Unless prior arrangements have been made with our office.
4. Accounts past 90 days will be referred to collections. A $100 collection fee will be added to accounts referred to collections and once with the agency, the patient must deal directly with the collection agency to clear the account.
5. By signing below, you acknowledge you have read and understand the above information.

Signature: _____ Date: _____

Medical Intake Form

Visit Date: _____

PATIENT INFORMATION		
Patient Name *(last, first, M.I):*	**Date of Birth**:	**Age:**
Reason for Visit:		

DRUG ALLERGIES	
Allergy:	Reaction:
Allergy:	Reaction:

CURRENT MEDICATIONS: *Include the name, strength/dose, & frequency taken for all prescribed, over-the-counter drugs, vitamins, supplements, inhalers, etc.:*

MEDICAL PROBLEMS: ***List any medical conditions***

SURGICAL HISTORY

Year	Type of surgery	Reason for surgery

FAMILY HISTORY

Maternal relatives with breast, ovarian, uterine, or colon cancer?	☐ Yes ☐ No
Family history? *If "Yes" please indicate the family member. If member is deceased, please indicate with "(D)"*	
☐ Yes ☐ No	**High blood pressure:**
☐ Yes ☐ No	**Heart disease:**
☐ Yes ☐ No	**Stroke:**
☐ Yes ☐ No	**Diabetes:**
☐ Yes ☐ No	**Cancer:**
☐ Yes ☐ No	**Other:**

SOCIAL HISTORY

Do you smoke cigarettes?	☐ Yes - How many/week?	☐ No	☐ Quit, year:
Do you drink alcohol?	☐ Yes - How many/day?	☐ No	☐ Quit, year:
Do you smoke marijuana?	☐ Yes	☐ No	
Do you use any illicit/IV drugs?	☐ Yes – describe:	☐ No	
Exercise regularly?	☐ Yes - *How many days/week?*	☐ No	

Gynecology Intake Form

Visit Date: _____

PATIENT INFORMATION

Patient Name *(last, first, M.I):*	**Date of Birth**:	**Age:**
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed		
Occupation:	**Primary/Referring Physician:**	
Preferred Pharmacy *(include street & zip code):*		

GYNECOLOGIC HISTORY *(skip questions that do not apply)*

MENSTRUAL & PREGNANCY HISTORY

TOTAL PREGNANCIES ____ FULL TERM ____ PREMATURE ____ MISCARRIAGES ____ ABORTIONS ____ # OF CHILDREN ___

Menstruation started at age:		Menopause started at age:
Last menstrual period *(first day)*:		Menstrual periods: ☐ Regular ☐ Irregular
Days between cycles:	Days of bleeding:	Flow (check one): ☐ Light ☐ Moderate ☐ Heavy

SEXUAL ACTIVITY

Are you sexually active? ☐ Yes ☐ No	Current partners: ☐ Male ☐ Female ☐ Both

INFECTION HISTORY

☐ None ☐ Chlamydia ☐ Gonorrhea ☐ Genital Herpes ☐ Trichomoniasis
☐ Syphilis ☐ HIV/AIDS ☐ Genital warts/HPV ☐ Pelvic Inflammatory disease ☐ Other:

CONTRACEPTION

Current method of birth control: ☐ Prescription: ☐ Hysterectomy ☐ Tubal ☐ Vasectomy ☐ Other:	Condom used? ☐ Yes ☐ No

PREVENTIVE CARE

When was your last pap smear? *(month/year)*: ☐ Normal ☐ Abnormal

When was your last **abnormal** pap smear? (month/year): ☐ Not applicable

Have you needed any of the following for an abnormal pap? ☐ Yes (check all that apply) ☐ No treatment required
☐ Colposcopy (year:) ☐ LEEP/Laser/ Conization (year:) ☐ Cryosurgery (year:)

When was your last mammogram? *(month/year):*	☐ Normal	☐ Abnormal
When was your last bone density scan? *(month/year):*	☐ Normal	☐ Abnormal
When was your last colonoscopy? *(month/year)*:	☐ Normal	☐ Abnormal

Have you received the HPV vaccine? ☐ Yes ☐ No	Have you received the COVID-19 vaccine? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Please indicate any symptoms in the last 30 days AND/OR any symptoms currently

☐ Yes ☐ No	Extremely painful periods	☐ Yes ☐ No	Frequent urination	☐ Yes ☐ No	Breast lumps
☐ Yes ☐ No	Abnormal vaginal discharge	☐ Yes ☐ No	Pain/Burning w/ urination	☐ Yes ☐ No	Breast pain
☐ Yes ☐ No	Irregular vaginal bleeding	☐ Yes ☐ No	Incontinence (leaking)	☐ Yes ☐ No	Nipple discharge
☐ Yes ☐ No	Pelvic Pain	☐ Yes ☐ No	Blood in urine		
☐ Yes ☐ No	Painful intercourse				

OFFICE USE ONLY

HGT: WGT: BP: / PULSE: RESP: HCG: