

**Welcome to OBGYN Associates.**

We are happy you have chosen our practice for your specific medical needs. Please fill out the enclosed forms and bring them with you to your appointment. *We do ask that you please arrive at our office at least twenty minutes before your scheduled appointment time, this enables us to complete our registration process.*

The charge for your initial appointment will be approximately \$237 to \$316, any additional services will be charged accordingly. Fees are to be paid at the time of service. We accept cash, personal check, Visa, MasterCard and Discover for payment. If you have one of the following insurance carriers we will file this charge with your insurance company on your behalf. If you do not have your current insurance card with you at your appointment you will need to pay at the time of service and file for reimbursement.

- |  |                                   |
|--|-----------------------------------|
| Advantage HMO                              | Community Health Alliance         |
| Sagamore                                   | Cigna PPO                         |
| Medicare                                   | United HealthCare                 |
| Blue Cross/Blue Shield/Anthem              | Aetna PPO                         |
| Select Health Network                      | Private HealthCare Systems (PHCS) |
| Indiana Medicaid MHS, Anthem or MDWise SHN |                                   |

**WE DO NOT ACCEPT MICHIGAN MEDICAID**

Many insurance companies are now requiring their members to use a preferred laboratory. Please inform us if you need to use a lab other than the South Bend Medical Foundation.

If you need a referral from your primary care physician, it is your responsibility to obtain the referral prior to your appointment. If you are unsure if you need a referral or if you have any questions regarding your benefits, please contact your insurance company.

Thank you.

Just a reminder that your appointment is scheduled for \_\_\_\_/\_\_\_\_/\_\_\_\_ @ \_\_\_\_:\_\_\_\_<sup>am</sup>/<sub>pm</sub>

**Please bring a list of your current medications including strengths and dosages.**

**OBGYN ASSOCIATES OF NORTHERN INDIANA, P.C.**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ INIT \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE ( ) \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_  
WORK PHONE ( ) \_\_\_\_\_ EXT \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_ SOCIAL SECURITY \_\_\_\_\_  
MARITAL STATUS: SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_  
ALTERNATE CONTACT NUMER ( ) \_\_\_\_\_ NAME \_\_\_\_\_

EMPLOYER \_\_\_\_\_  
ADDRESS \_\_\_\_\_

PARENT/SPOUSE NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE ( ) \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_  
SOCIAL SECURITY \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_

NEAREST RELATIVE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_ ID# \_\_\_\_\_ ACC# \_\_\_\_\_  
CARDHOLDER NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
ADDRESS \_\_\_\_\_ SOCIAL SECURITY \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ ID# \_\_\_\_\_ ACC# \_\_\_\_\_  
CARDHOLDER NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
ADDRESS \_\_\_\_\_ SOCIAL SECURITY \_\_\_\_\_

REFERRED BY \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

I authorize OBGYN Associates of Northern Indiana to release information concerning illness or treatments to my insurance carrier and also direct payment to the physician(s) who rendered medical services.

I will accept responsibility for payment of fees submitted by OBGYN Associates of Northern Indiana for any balance not covered by my insurance.

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

As parent/guardian, I give my permission to consult with and/or treat \_\_\_\_\_  
\_\_\_\_\_. I also authorize OBGYN Associates of Northern Indiana to submit fees for  
services rendered to my insurance carrier for payment. If, for any reason, the fees are not covered I agree to  
accept responsibility for the outstanding balance.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**OBGYN ASSOCIATES OF NORTHERN INDIANA, PC**

**MEDICAL INFORMATION RELEASE**

**I hereby authorize OBGYN ASSOCIATES OF NORTHERN INDIANA, P.C., to release any medical or appointment information to the following persons:**

**(i.e. – spouse, parents, children or significant other)**

<u>NAME</u>	<u>RELATIONSHIP</u>
1. _____	_____
2. _____	_____
3. _____	_____

**SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

**TO BE KEPT IN PATIENT'S CHART AT ALL TIMES**

**Please complete both sides of form.**

# OB-GYN ASSOCIATES OF NORTHERN INDIANA, P.C.

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

## **INITIAL PATIENT SELF-HISTORY FORM**

Provide all information requested to the best of your ability.

**ALLERGIES** (Include medications, Latex, Iodine)

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## **GYNECOLOGIC HISTORY**

Age at first menses (period) \_\_\_\_\_ Age at menopause (if applicable) \_\_\_\_\_

(The following questions refer to your "natural" periods when not on birth control pills or hormones)

Usual # of days of period \_\_\_\_\_ Period interval (1<sup>st</sup> day to 1<sup>st</sup> day) \_\_\_\_\_ days

How many days are: Heavy \_\_\_\_\_ Medium \_\_\_\_\_ Light \_\_\_\_\_

Have you ever had an abnormal pap smear? \_\_\_\_\_

If yes, how was it treated? \_\_\_\_\_ When? \_\_\_\_\_

Date of last pap smear \_\_\_\_\_ Have you had a mammogram? \_\_\_\_\_ When? \_\_\_\_\_ Result \_\_\_\_\_

Types of birth control used, including vasectomy \_\_\_\_\_

Have you had any gynecologic surgery? (Including Tubal Ligations, D&C's, Cryo, Leep, Ovarian surgery)

If yes, what kind? \_\_\_\_\_ When? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have any knowledge of your mother using hormones (DES, Diethylstilbestrol) during her pregnancy with you? \_\_\_\_\_

## **PREGNANCY HISTORY**

# of full-term deliveries \_\_\_\_\_ # of premature deliveries \_\_\_\_\_ # of miscarriages \_\_\_\_\_ Was surgery needed? \_\_\_\_\_

# of abortions \_\_\_\_\_ Any complications? \_\_\_\_\_ Any "tubal" pregnancies? \_\_\_\_\_ When? \_\_\_\_\_

# of vaginal deliveries \_\_\_\_\_ # of Cesarean sections \_\_\_\_\_ Years of deliveries \_\_\_\_\_

Any serious complications during your pregnancies or deliveries? \_\_\_\_\_

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## **RISK FACTORS**

Your answers to these questions help us to determine if you have risk factors for cancer, infections or AIDS:

Have you ever received a blood transfusion? \_\_\_\_\_ Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you consume alcohol? \_\_\_\_\_ How often? \_\_\_\_\_

Have you ever used marijuana, cocaine, heroin, barbituates, or speed? \_\_\_\_\_ If yes, last used? \_\_\_\_\_ Any needles? \_\_\_\_\_

Age at first intercourse \_\_\_\_\_ Total # of sexual partners \_\_\_\_\_ Total # of sexual partners in last year \_\_\_\_\_

Have you had any sexually transmitted infections? \_\_\_\_\_ If yes, what? \_\_\_\_\_ When? \_\_\_\_\_

Do you believe yourself to be at risk of exposure to the AIDS virus? \_\_\_\_\_

**Please complete both sides of form.**

**SURGERY** (Other than gynecologic)

TYPE	WHEN	DOCTOR	COMPLICATIONS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**HOSPITALIZATIONS** (Non-surgical, other than pregnancy)

CONDITION	WHEN	DOCTOR	TREATMENT
_____	_____	_____	_____
_____	_____	_____	_____

**PAST AND PRESENT MEDICAL PROBLEMS**

<input type="checkbox"/> Abnormal PAP, h/o	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypercoagulable disorder	<input type="checkbox"/> Preterm delivery, prior
<input type="checkbox"/> Anemia	<input type="checkbox"/> DES Exposure	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Psychiatric disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Pulmonary embolism
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Drug/alcohol use	<input type="checkbox"/> Incompetent cervix	<input type="checkbox"/> Recurrent miscarriages
<input type="checkbox"/> Bartholin's gland cyst	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Infertility	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Blood transfusion, h/o	<input type="checkbox"/> Family hx of genetic disorder	<input type="checkbox"/> Neonatal death, prior	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Breast cancer	<input type="checkbox"/> Fetal death, prior	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breast mass	<input type="checkbox"/> Fibroid uterus	<input type="checkbox"/> Obesity	<input type="checkbox"/> Uterine cancer
<input type="checkbox"/> Bruising / bleeding disorder	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Ovarian cancer	<input type="checkbox"/> UTI, h/o recurrent
<input type="checkbox"/> Cerebrovascular accident	<input type="checkbox"/> Genital herpes, exposure	<input type="checkbox"/> Ovarian cyst	<input type="checkbox"/> Vaginal infections, recurrent
<input type="checkbox"/> Cervical cancer	<input type="checkbox"/> Genital herpes, h/o	<input type="checkbox"/> PID	<input type="checkbox"/> STD
<input type="checkbox"/> Clotting disorder	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Polycystic ovary syndrome	
<input type="checkbox"/> Coronary heart disease	<input type="checkbox"/> Hemoglobinopathy	<input type="checkbox"/> Prolapsed uterus	
<input type="checkbox"/> Cystocele	<input type="checkbox"/> Hepatitis/Liver disease	<input type="checkbox"/> Premature rupture of membranes	

Other Medical/Surgery History not listed \_\_\_\_\_

**FAMILY HISTORY** Include Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF), and Children (C) only.

Diagnosis

◀ ↙ Family member Indicated by M-Mother, F-Father, B-Brother, C-Child, etc.

Alive and Well <input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Alcoholism	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Downs syndrome	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Asthma	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Hemophilia-A	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Autoimmune disorder	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Hyperlipidemia	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Breast cancer	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Hypertension	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Cervical cancer	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Mental illness	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Coagulopathy	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Mental retardation	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Colon cancer	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Muscular dystrophy	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Coronary artery disease	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Ovarian cancer	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Cerebrovascular accident	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Seizure disorder	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Cystic fibrosis	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Sickle cell disease	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Depression	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Spina bifida	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Developmental delay	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Thyroid disease	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
		Other <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>

Other Family History not listed \_\_\_\_\_

Check if adopted/family history not known