PATIENT INFO SHEET
(BLACK INK ONLY PLEASE)

PLEASE FILL OUT AND PRINT

DATE: CHART #

PATIENT

LAST NAME FIRST NAME M.I.

SSN # - - BIRTHDATE / / AGE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ LIVING WITH PARTNER ☐ DIVORCED ☐ WIDOWED

PHONE ( ) CELL ( ) BEST # ( )

MAILING ADDRESS: EMAIL:

CITY STATE ZIP CODE

EMPLOYER ADDRESS

CITY STATE ZIP CODE PHONE ( )

WHO IS YOUR PRIMARY CARE PHYSICIAN?

PHARMACY OF YOUR CHOICE? **PHONE ( )**

WHO IS YOUR MEDICAL INSURANCE THROUGH? ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT** ☐ **NONE (PRIVATE PAY)**

INSURED'S INFORMATION: ***(IF SUBSCRIBER IS OTHER THAN YOURSELF AND/OR IF YOU ARE DUAL-INSURED, THEIR INFO GOES HERE)***

LAST NAME FIRST NAME M.I.

SSN # BIRTHDATE / / PHONE ( )

ADDRESS CITY STATE ZIP CODE

EMPLOYER ADDRESS

CITY STATE ZIP CODE PHONE ( )

IN CASE OF EMERGENCY PLEASE NOTIFY: (Name of someone not living with you or not listed above):

NAME: PHONE ( )

REFERRED BY: ☐ **FRIEND** ☐ **RELATIVE** ☐ **PHYSICIAN** ☐ **EMPLOYER**

PRIMARY INSURANCE CARD	SECONDARY INSURANCE CARD

ASSIGNMENT OF INSURANCE BENEFITS

CONSENT TO OBTAIN INFORMATION AND IRREVOCABLE ASSIGNMENT OF BENEFITS: The undersigned hereby authorizes the physician, his/her agents or representatives, to verify the eligibility of Medicare coverage, Title XVIII of the Social Security Administration and/or Medi-Cal, Title XIX of the Welfare and Institutions Code. This authorization and consent also applies to any other third party payor determined to provide medical expense coverage on my behalf including health insurance coverages. I hereby irrevocably assign to the physician, to the extent permitted by law, all rights and benefits payable on my behalf from the above mentioned coverage program(s). I further understand that I am primarily responsible for all physician charges regardless of any assignment of benefits. If the insurance denies coverage or not pay in a reasonable time, I agree to make satisfactory arrangements to settle the account with the physician's request. I further acknowledge that any payable benefits, when received by physician, will be credited to my account, according to the above assignment. The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient's general agent to execute the above and accept its terms.

PATIENT/PARENT/GUARDIAN/CONSERVATOR DATE

IF OTHER THAN PATIENT, INDICATE RELATIONSHIP WITNESS

OB QUESTIONNAIRE

DATE_____

NAME _____ BIRTHDATE _____ AGE _____

ADDRESS _____

OCCUPATION _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ LIVING WITH PARTNER ☐ DIVORCED ☐ WIDOWED

FATHER OF THE BABY _____

NAME OF PERSON REFERRING YOU TO OUR OFFICE _____

HOW MANY TIMES HAVE YOU BEEN PREGNANT ALL TOGETHER? _____

HAVE YOU HAD ANY MISCARRIAGES? _____

HAVE YOU HAD ANY ABORTIONS? _____

BIRTHS:

DATE OF BIRTH	BIRTH WEIGHT	SEX	LENGTH OF LABOR	HOW MANY MONTHS	VAGINAL OR CESAREAN	ANESTHESIA	PLACE OF BIRTH	PROBLEMS NO/YES

DO YOU HAVE, OR HAVE YOU EVER HAD:

	NO	YES		NO	YES
ASTHMA			BLOOD TRANSFUSIONS		
TUBERCULOSIS			HERPES		
EPILEPSY			GONORRHEA		
THYROID DISEASE			SYPHILIS		
PSYCHIATRIC DISORDER			CHLAMYDIA		
HIGH BLOOD PRESSURE			GENITAL WARTS &/OR HPV		
HEART DISEASE			SURGERIES		
RHEUMATIC FEVER			PROBLEMS WITH ANESTHESIA		
CANCER			PREVIOUS ABNORMAL PAP SMEARS		
KIDNEY DISEASE			UTERINE ABNORMALITIES		
DIABETES			INFERTILITY PROBLEMS		
HEPATITIS			EXPOSURE TO DES		
LIVER OR GALL BLADDER DISEASE			ANY HOSPITALIZATIONS		
BLOOD CLOTS IN THE LEGS OR LUNGS			ANY OTHER MEDICAL PROBLEMS		
MAJOR ACCIDENTS					

NAME _____ DATE _____

DO YOU:

	NO	YES
HAVE ALLERGIES TO ANY MEDICATIONS?		
IF SO, WHICH ONES? _____		
SMOKE OR USE TOBACCO IN ANY FORM?		
IF SO, HOW MUCH DO YOU SMOKE OR USE? _____		
DRINK ALCOHOL?		
IF SO, HOW MUCH DO YOU DRINK? _____		
USE, OR HAVE YOU EVER USED STREET DRUGS?		
IF SO, DATE OF LAST USE AND SUBSTANCE USED? _____		
HAVE YOU TAKEN ANY MEDICATIONS SINCE BECOMING PREGNANT?		
IF SO, MEDICATION AND DOSE? _____		

HAVE YOU, THE FATHER, OR ANYONE IN EITHER FAMILY EVER BEEN DIAGNOSED WITH?

	NO	YES
THALASSEMIA		
NEURAL TUBE DEFECT (MENINGOMYELOCELE, OPEN SPINE, SPINA BIFIDA, ANENCEPHALY)		
DOWN SYNDROME (MONGOLISM)		
MUSCULAR DYSTROPHY		
CYSTIC FIBROSIS		
HEMOPHILIA		
HUNTINGTON CHOREA		
INHERITED GENETIC OR CHROMOSOMAL DISORDER, ANY OTHER BIRTH DEFECT		
TAY SACH'S DISEASE (Are you or the father of the baby Jewish or of French-Canadian descent?)		
SICKLE CELL DISEASE OR TRAIT (Are you or the father of the baby of African-American descent?)		
MENTAL RETARDATION		
VENOUS THROMBOSIS OR PULMONARY EMBOLUS (Blood clots in the legs or lungs)		

SO FAR WITH THIS PREGNANCY, HAVE YOU HAD?

	NO	YES		NO	YES
FEVER			CONSTIPATION		
RASH			HEADACHE		
VAGINAL BLEEDING			ABDOMINAL PAIN		
VAGINAL DISCHARGE			BURNING WITH URINATION		
VOMITING			ANY OTHER PROBLEMS		

WHAT WAS THE FIRST DAY OF YOUR LAST NORMAL MENSTRUAL PERIOD? _____

BEFORE YOU BECAME PREGNANT, DID YOU HAVE A PERIOD EVERY MONTH? _____

WERE YOU USING ANY METHOD OF BIRTH CONTROL WHEN YOU BECAME PREGNANT? _____

HAVE YOU HAD A PREGNANCY TEST YET? _____

IF SO, WHEN WAS IT PERFORMED AND WHAT WERE THE RESULTS? _____