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

DAN M . DOROUGH, MD

GYNECOLOGY QUESTIONNAIRE

DATE_____

NAME_____ **OCCUPATION** _____

NAME OF PERSON REFERRING YOU TO OUR OFFICE_____

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

HOW MANY TIMES HAVE YOU BEEN PREGNANT? _____ **HOW MANY CHILDREN DO YOU HAVE?** _____

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

HOW OLD WERE YOU WHEN YOUR PERIODS STARTED? _____ **DO YOU HAVE A PERIOD EVERY MONTH?** _____

HOW MANY DAYS DOES YOUR PERIOD LAST? _____ **IS YOUR PERIOD HEAVY, MEDIUM OR LIGHT?** _____

HAVE YOU EVER HAD SEX? ☐ **YES** ☐ **NO**

ARE YOU CURRENTLY SEXUALLY ACTIVE? ☐ **YES** ☐ **NO**

IF YES TO ABOVE QUESTIONS: ☐ **SAME PARTNER** ☐ **MULTIPLE PARTNERS**

SEXUAL PARTNERS ARE: ☐ **MEN** ☐ **WOMEN**

WHEN WAS YOUR LAST PAP SMEAR? _____

WHICH METHOD OF BIRTH CONTROL (IF ANY) ARE YOU USING? _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

	NO	YES		NO	YES
ASTHMA			SYPHILIS		
TUBERCULOSIS			CHLAMYDIA		
SEIZURES/EPILEPSY			GENITAL WARTS AND/OR HPV		
THYROID DISEASE			SURGERIES		
DEPRESSION/ANXIETY/PSYCHIATRIC DISORDER			PROBLEMS WITH ANESTHESIA		
HIGH BLOOD PRESSURE			PREVIOUS ABNORMAL PAP SMEARS		
HEART ATTACK/HEART PROBLEMS			UTERINE ABNORMALITIES		
RHEUMATIC FEVER			PROBLEMS GETTING PREGNANT		
CANCER			EXPOSURE TO DES		
KIDNEY PROBLEMS			ANY HOSPITALIZATIONS		
DIABETES			ANY OTHER MEDICAL PROBLEMS		
HEPATITIS					
LIVER OR GALL BLADDER DISEASE			DO YOU SMOKE TOBACCO?		
BLOOD CLOTS IN YOUR LUNGS OR LEGS			DO YOU SMOKE MARIJUANA?		
MAJOR ACCIDENTS			DO YOU DRINK ALCOHOL?		
BLOOD TRANSFUSIONS			DO YOU OR HAVE YOU USED STREET DRUGS?		
HERPES					
GONORRHEA					

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS? ☐ **YES** ☐ **NO** **IF SO, WHICH ONES?** _____

_____

PLEASE LIST ALL CURRENT MEDICATIONS: _____

_____

****SOME MEDICAL CONDITIONS ARE NOT INCLUDED IN YOUR ANNUAL EXAM & MAY RESULT IN AN ADDITIONAL COPAY OR HAVE ADDITIONAL COSTS APPLIED TO YOUR DEDUCTIBLE PER YOUR INSURANCE BENEFITS****