

Please complete these forms and bring with you for your appointment.

Gynecologic Oncology Associates

Patient Name		
Street Address		
City	State	Zip Code
Home Phone		Work Phone
Date of Birth		Social Security #
Employer		
Emergency Contact		Phone
Referring Physician		
Spouse Name		
Spouse Employer		
Spouse's Business Phone		
Spouse's Date of Birth		Spouse's Social Security #

Primary Insurance Data

Plan Name		
Mailing Address		
City	State	Zip Code
Phone Number		Effective Date
Policy Number		Group Number
Policy Holder		Date of Birth
HMO (Y / N)	PPO (Y / N)	Co-Pay \$
PreAuthorization Required (Y / N)		Second Opinion (Y / N)
Medicare Number		Medicaid Number
Do you have a Secondary Insurance Policy? (Y / N)		
Plan Name		

Insurance Authorization

I request that payment of authorized Medicare and insurance benefits to be made to me or on my behalf to Gynecologic Oncology Associates for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or benefits payable for related service. I understand that I am responsible for any amount not covered by insurance.

Signature _____

Date _____

Gynecologic Oncology Associates

Date _____

Name _____ Age _____

Marital Status _____ Occupation _____

Reason for visit:

GYNECOLOGIC HISTORY:

Last menstrual period _____ Age First Period _____

How long between cycles? _____ Days Duration? _____

Pain/ Cramps (Please circle one): No Mild Severe

When was your last pap smear? _____ Results _____

Have you ever had an abnormal pap smear? (Please circle one) Yes No

If yes, Date _____ Treatment _____

Mammogram: No Yes Date _____ Results _____

Are you sexually active? No Yes Method of Birth Control _____

Do you have pain with intercourse? No Yes

Do you lose urine when you cough? No Yes

Have you ever been pregnant? No Yes

Number of Pregnancies? _____ Number of Births? _____

Gynecologic Oncology Associates

MEDICAL HISTORY:

Have you ever had or do you have:

	NO	YES	Explain
High Blood Pressure	_____	_____	_____
Heart Disease	_____	_____	_____
Diabetes	_____	_____	_____
Seizures	_____	_____	_____
Asthma	_____	_____	_____
Arthritis	_____	_____	_____
Liver Disease	_____	_____	_____
Kidney Disease	_____	_____	_____
Thyroid Disease	_____	_____	_____
Bleeding Disorders	_____	_____	_____
Blood Clots	_____	_____	_____
Stroke	_____	_____	_____
Emphysema	_____	_____	_____
Ulcers	_____	_____	_____
Colitis	_____	_____	_____
Glaucoma	_____	_____	_____
Anemia	_____	_____	_____
Lupus	_____	_____	_____
Cancer	_____	_____	_____
Genital Warts	_____	_____	_____
Herpes	_____	_____	_____
Venereal Disease	_____	_____	_____

Other (Explain):

SURGICAL HISTORY

Please list any surgeries you have had:

<u>Year</u>	<u>Hospital</u>	<u>Procedure</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any hospitalizations for medical illness:

<u>Year</u>	<u>Hospital</u>	<u>Procedure</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you under another doctor's care?

<u>Doctor</u>	<u>Medical Problem</u>
_____	_____
_____	_____
_____	_____

Current Medications (include aspirin, hormones, etc.)

Allergies to Medications:

HEALTH MAINTENANCE

Do you smoke? No_____ Yes_____ Cigarettes per day _____ Years _____

Do you drink? No_____ Yes_____ Amount _____

Have you ever had a blood transfusion? No_____ Yes_____ Year _____

Any disease that runs in the family?
