



MT. AUBURN OBSTETRICS & GYNECOLOGIC ASSOC., INC.

**PLEASE COMPLETE THIS PATIENT REGISTRATION FORM
AND BRING IT WITH YOU AT THE TIME OF YOUR VISIT**

PLEASE PRINT

Patient Name _____ Birth Date _____

Referred by _____ Age _____

Patient's SS # _____ Home Phone _____

Patient's Address _____

City, State and Zip Code- _____

Patient's Employer and Employer Address _____ Employer Phone Number _____

Spouse _____ Date of Birth _____ Phone _____

Nearest Relative _____ Address _____ Phone _____

Spouse's Employer and employer's address _____

Emergency Notification other than Spouse, Name and Address _____

Bill to: (Please complete if other than patient)

Responsible Person name _____

Street _____ Phone _____

City, State, Zip _____ s s # _____

Employer _____ Employer Phone _____

Patient's Relationship to insured CI Self Spouse Child CI Other

Primary Insurance _____ Policy Number _____

Secondary Insurance _____ Policy Number _____

Welfare Number _____ ADC Number _____ Medicare Number _____

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM AUTHORIZATION

I hereby authorize the above physician(s) to release any information regarding services rendered by him and allow a photocopy of my signature to be used to file insurance

I hereby authorize and direct my insurer to issue payment check(s) for benefits due me for the services rendered by the above named physician(s) to be made directly to him. Regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered.

(Date)

(Responsible person, Parent or Guardian, if Minor)

Please complete if Medicare:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carriers any information needed for this or a related **medicare** claim. I request the payment of authorized benefits be made on my behalf.

Name _____ Date _____

In the past 12 months have you had any of the following symptoms?

Unexplained fevers	Y N	Leaking of urine	Y N
Weight loss more than 5- 10 pounds	Y N	Swelling in feet or ankles	Y N
Trouble with eyes or vision	Y N	Pain in muscles or joints	Y N
Frequent headaches	Y N	Change in mole or skin growth	Y N
Nosebleeds	Y N	Fainting or passing out	Y N
Chest pain, pressure or heaviness	Y N	Difficulty sleeping	Y N
Shortness of breath or wheezing	Y N	Difficulty concentrating	Y N
Frequent indigestion or heartburn	Y N	Depression	Y N
Frequent constipation or diarrhea	Y N	Unusual bleeding or bruising	Y N
Urinating more than twice per night	Y N	Abdominal Pain	Y N

Do you smoke cigarettes Y N How much? _____
Do you drink alcohol Y N How much? _____
Do you use any "street drugs" Y N How often? _____
Do you drink caffeinated beverages Y N How much? _____
Do you exercise regularly Y N Times per week _____
Do you take vitamins Y N Type _____
Do you always wear a **seatbelt** when riding in a car Y N
Do you wear a **sunblock** when exposed to the sun Y N
Do you perform regular self breast exams? Y N
When was your last dental checkup? _____
Are you now in a relationship with a person who threatens you or physically hurts you Y N
Are you sexually active Y N With more than one partner Y N

Do you have an immediate relative with any of the following?

Relation:

Cancer Y N
cervical Y N _____
uterine Y N _____
ovarian Y N _____
breast Y N _____
colon Y N _____
other _____

Diabetes Y N _____
Insulin? Y N _____
High Blood Pressure Y N _____
Heart Disease Y N _____

Do you take any medications regularly?

Medication _____ Dose _____

Do you have any allergies to medications?

Name of Medication _____

Who is your family doctor or internist? _____