DUPONT OBSTETRICS & GYNECOLOGICAL ASSOCIATES, P.C.

11123 PARKVIEW PLAZA DRIVE, SUITE 204
FORT WAYNE, IN, 46845
(260) 490-6260

PATIENT HISTORY

GENERAL INFORMATION

Patients Name	Today's Date
Reason for visit today: _____	
DOB: _____	
Marital Status: _____ Years Married: _____	

MENSTRUAL HISTORY:

Last normal period: _____	Age of first period: _____
Interval between cycles (# of days): _____	Duration of period: _____
Tampon use: [Yes] [No] [Occasionally]	Cramps with periods: [Yes] [No]
If you no longer get your period, at what age did you stop: _____	

PREGNANCY HISTORY:

# of pregnancies _____	# of deliveries _____	# vaginal _____	# C/section _____
# of abortions _____	# before 3 months _____	# after 3 months _____	
# of miscarriages _____	# within first 3 months _____	# greater than 3 months _____	
# of ectopics: _____			
Complications: _____ _____			

SEXUAL HISTORY:

Sexually active? [Yes] [No]	If no, date of last sexual contact: _____
Age of first coitus: _____	Total # of partners: _____

How long with current partner? _____	More than one current partner? _____

CONTRACEPTIVE HISTORY:

Current birth control method: _____					
Are you requesting birth control method today? [Yes] [No]					
Pills □	Patch □	Diaphragm □	Depo Provera Shot □	IUD □	Tubal Ligation □
Do you use condoms: Always □ Most times □ Sometimes □ Never □					

SEXUALLY TRANSMITTED DISEASE HISTORY:

History of sexually transmitted diseases: [Yes] [No]
If yes, give dates and treatment received: Gonorrhea: _____ Chlamydia: _____ Syphilis: _____ Herpes: _____ HPV/Warts: _____ Hepatitis: _____
Do you feel you have any risk factors for HIV/AIDS? [Yes] [No]

ABNORMAL PAP SMEAR HISTORY:

Any history of abnormal Pap Smear: [Yes] [No]	When: _____
What test did you have done: _____	
Any treatment: [Yes] [No]	If yes, specify: _____
Date of last Pap Smear: _____	Results: _____

DES IN UTERO EXSPOSURE HISTORY:

Any history of DES exposure? [Yes] [No]
If yes, are you a: DES daughter □ DES mother □

What problems have you had as a result of your DES exposure: _____

_____

INFERTILITY HISTORY:

Do you have a history or concern regarding infertility? [Yes] [No]

# of months trying to conceive? _____

History of previous work-up or treatment (please describe): _____

_____

Do you have a history of ENDOMETRIOSIS? [Yes] [No]

When diagnosed: _____ | How diagnoses? _____

Previous treatment: _____

_____

Have you any hospitalization not previously mentioned? [Yes] [No]

If history hospitalizations, when and why? _____

_____

GYNECOLOGICAL HISTORY:

Please circle if you have had a history of or are currently experiencing any of the following:

1. Abnormal/irregular periods	8. Vaginal infections (ie, yeast, trichomanas, bacterial vaginosis)
2. Pelvic pain/pelvic inflammatory disease (PID) infections of tubes, ovaries, uterus	9. Vaginal bleeding/spotting between periods
3. Ovarian cysts	10. Urinary tract infections
4. Fibroids	11. Urinary problems (ie frequency, urgency, difficulty, leaking)
5. Gynecologic cancer: (ovarian, uterine, cervix)	12. Brest discharge

6. Pain during or after intercourse 7. Abnormal vaginal discharge	13. Brest biopsy 14. Biopsies of uterine, cervis, vagina or vulva
Describe all circled numbers above: _____ _____ _____ _____	

GYNECOLOGICAL SURGERY:

History of gynecological surgery? If yes, give date, type of procedure and any complications: _____ _____

MENOPAUSE:

If you no longer have periods, do you have any symptoms? [Yes] [No]
If yes, specify: _____ _____
Do you take or have you ever taken Hormone Replacement Therapy (HRT)? [Yes] [No]
If yes, what do/did you use? _____
If no, do you wish to discuss HRT? [Yes] [No]
Do you have any difficulties with bladder control? [Yes] [No]
If yes, specify: _____ _____

ALLERGIES:

Medication allergies (list drugs and reaction to them): _____ _____

MEDICAL HISTORY:

History of Blood transfusion? [Yes] [No]

If yes, when and why? _____

Please circle if you have had problems with or are currently experiencing any of the following:

High Blood Pressure	**T.B.**	**Hepatitis of jaundice**	**Blood clots in legs/lungs**
Diabetes	**Hay fever**	**Thyroid disease**	**HIV/AIDS**
Cancer	**Abdominal discomfort**	**Head or neck radiation**	**Epilepsy/seizures**
Heart Disease	**Indigestion**	**Headache**	**Nuerological disorders**
Chest Pain	**Nausea**	**Kidney disease**	**Excess hair growth/loss**
Chest tightness	**Vomiting**	**Arthritis/Lupus**	**Eating disorder**
Shortness of breath	**Constipation**	**Low back problems**	**Domestic violence**
Swollen ankles	**Diarrhea**	**Skin diseases**	**Osteoporosis**
Palpitations	**Blood in stool**	**Blood disorders**	**Eye problems or glaucoma**
Lightheadedness	**Ulcers**	**Anxiety**	**Hearing problems**
Stroke	**Change in bowel habits**	**Depression**	**Fatigue**
Rheumatic fever	**Unexplained weight gain / weight loss**	**Breast problems**	**Acne**
Asthma	**Hemmorrhoids**	**Anemia**	**Childhood illnesses,**
Colitis	**Gall bladder disease**	**Alcohol abuse**	**Chicken pox, measles, rubella**
Bronchitis	**Elevated cholesterol**	**Drug Abuse**	**Other**
Pneumonia		**Gout**	
Persistent cough			

Describe anything circled above: _____

_____

Are you currently on any other medication not previously mentioned? [Yes] [No]

Please list: _____

_____

Have you had any hospitalizations not previously mentioned? [Yes] [No]

If history of hospitalization, when and why? _____

_____

History of general surgery? If yes, give date, type of procedure and any complications:

_____

_____

_____

VACCINATION STATUS:

Have you had:			
Pneumovax immunization	[No]	[Yes]	When: _____
Hepatitis B immunization	[No]	[Yes]	When: _____
Flu immunization	[No]	[Yes]	When: _____
Tetanus immunization	[No]	[Yes]	When: _____
MMR (measles, mumps, rubella)	[No]	[Yes]	When: _____
PPD testing (tuberculosis screening)	[No]	[Yes]	When: _____

WHEN WAS YOUR LAST:

Pap smear _____	Breast Exam _____	Stool check for blood _____
Mammogram _____	Cholesterol check _____	Sigmoidescopy _____
Skin exam for cancer _____		

FAMILY HISTORY:

Please list any family members with history of chronic medical illness (parents/siblings, children).

Hypertension _____

Diabetes _____

Asthma _____

Seizure disorder _____

Bleeding clotting disorder _____

Thyroid disease _____

Connective tissue disease _____	
Birth defects _____	
Mental retardation _____	
Other _____	
Any family history of cancer? [Yes] [No]	
If yes, list which family member.	
Breast _____	Cervix _____
Uterus _____	Ovaries _____
Lungs _____	Colon _____
Other _____	

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DISCLOSURE AGREEMENT

GENERAL INFORMATION

Patients Name	Today's Date

REASON FOR TODAY'S VISIT

☐ Routine Preventative Exam (I have no medical complaint or significant problem/abnormality that I am aware of).

☐ I have a problem/complaint that I wish evaluated/treated by doctor.

My chief complaint is: _____

_____

☐ My insurance plan covers Preventative Medical Services.

☐ My insurance plan *does not cover* Preventative Medical Services.

☐ I don't know if my insurance plan covers Preventative Medical Services

I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf, however, if my insurance company denies payment for any reason (e.g. not-covered services does not pay for preventative medicine visits, my failure to secure a referral from my primary care physician). I will pay for same upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is for the purpose of this agreement, a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visits with a diagnosis that was encountered and documented in my medical record. Thus to ask this office to change a diagnosis solely for the purpose of securing a reimbursement form an insurance carrier is inappropriate and may result in a fraudulent act.

In the event that I do not pay for these or any other services provided me when due, I agree to pay all cost of collection, including reasonable attorney fees, whether or not a law suit is commences as part of the collection process.

BY: _____
patient (or responsible party if patient is minor)

WITNESS: _____

This disclosure agreement form is provided with the understanding that the publisher is not engaged in rendering legal or accounting advice.

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INFORMATION & PAYMENT AUTHORIZATION

PATIENT INFORMATION

Name (Last, First, M.I.)	Age	Sex	Date of Birth
Address	City	State	Zip Code
Home Telephone	Marital Status	Spouse Name	
Social Security #	Employer		Work Telephone
Referring Doctor	Family Doctor		

RESPONSIBLE PARTY/GUARDIAN (if applicable)

Name (Last, First, M.I.)	Relationship to Parent		Home Telephone
Address	City	State	Zip Code
Social Security #	Employer		Work Telephone

INSURANCE INFORMATION

Name of Carrier (Primary Insurance)	Policy Number		Group Number
Name of Insured (as it appears on card)	Social Security #	Date of Birth	Relationship
Employer Name & Address			
Name of Carrier (Secondary Insurance)	Policy Number		Group Number
Name of Insured (as it appears on card)	Social Security #	Date of Birth	Relationship
Employer Name & Address			

EMERGENCY NOTIFCATION (please list two)

Name (Last, First, M.I.)	Address	Telephone	Relationship
Name (Last, First, M.I.)	Address	Telephone	Relationship

PAYMENT AUTHORIZATION

I hereby authorize payment of medical benefits for services provided be paid directly to DUPONT OBSTETRICS & GYNECOLOGICAL ASSOCIATES, P.C. I further authorize the release of any medical or other information necessary to process claims to my insurance company or its agents.

_____ _____

(signature) (date)

How do you plan to pay for today's services? □ cash □ check □ Visa/Master Card

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UNDERSTANDING YOUR INSURANCE BENEFITS

TO OUR PATIENTS

IT IS YOUR RESPONSIBILITY TO KNOW THE FOLLOWING:

- What managed care plan are you in?
- Read your medical insurance benefits manual. (Usually supplied by employer)
- Where does your lab work (pap smears, cultures, blood work) need to go?
- Know where you should go for diagnostic services, (ultrasounds, mammograms)

Please tell our nurses where your lab work needs to go. Our office will do our best to get your labs to your "in-network" laboratory, with your help. Sending your lab work to the incorrect place could cause a reduction in your benefits or eventually your claim being denied.

Ultimately it is your responsibility to know what your insurance benefits are.

I know where my labs need to be sent □

Send them to the following lab _____

I do not know where my labs need to be sent □

_____ _____

(signature) (date)

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POLICY REGARDING PAYMENT

AGREEMENT (please initial each paragraph after reading carefully)

____ Patients, including those who carry medical or surgical insurance, should be aware services furnished are charged to the patient. Parents are responsible for payment of all services provided to minors. As a courtesy, we will bill your insurance company and credit collections to your account. If there are any problems with the insurance, it is the covered party's responsibility to handle the matter with the insurance company.

____ You as the patients/parent will be responsible for your share of all charges at date of service. For example, if you have a policy that pays 80/20, you will be required to pay 20% at the time of service. If your insurance has a co-pay, you will be required to pay the co-pay amount at the time of service. If your insurance has a deductible that has not been met, you will be required to pay in full at the time of service. If your insurance company fails to pay within 45 days, you will be responsible to pay the balance in full. It is your responsibility to determine benefits covered by your insurance.

____ Most misunderstandings about insurance coverage can be avoided if you understand your policy and know what it will cover. If your insurance does not cover routine check-ups or blood work, you will be required to pay in full at the time of service.

____ In addition to charges from this office, the patient may be billed separately for outside services such as laboratory tests, x-rays, and professional reading of these tests. The patient (Guarantor) is responsible for all charges for these services.

____ All insurance claims processed by this office, prior to payment in full, are assigned to be paid directly to DUPONT OBSTETRICS & GYNECOLOGICAL ASSOCIATES, P.C. Your cooperation with the terms of this assignment will be appreciated.

ASSIGNMENT OF BENEFITS

I, the undersigned, hereby authorize payment of medical and surgical benefits directly to DUPONT OBSTETRICS & GYNECOLOGICAL ASSOCIATES, P.C.

I have read the above and realize all medical and surgical charges incurred by me, or my dependants, for services rendered or directed by DUPONT OBSTETRICS & GYNECOLOGICAL ASSOCIATES, P.C. are my financial responsibility. I shall also be responsible for any attorney fees, court costs, and collection agency fees required to collect these services.

_____ _____

signed (patient or parent) (date)

_____ _____

witness (date)

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PAYMENT AGREEMENT

FINAL AGREEMENT

I, _____ AGREE TO ASSUME RESPONSIBILITY FOR BALANCE DUE OF SERVICES RENDERED THAT WOULD NOT BE COVERED UNDER A CONTRACTED INSURANCE AGREEMENT, THAT DOCTOR IS CONTRACTED WITH.

IT IS NOT DUPONT OBSTETRICS & GYNECOLOGICAL ASSOCIATES, P.C. RESPONSIBILITY TO DETERMINE COVERAGE OR GO AFTER PAYMENT WITH YOUR INSURANCE COMPANY.

_____ _____

(signature) (date)