KURT D JONES, MD, FACOG CENTER FOR WOMENS HEALTH

Triple i/CliniForm

PATIENT REGISTRATIC

Name ____________________ SS# ____________

Street Address ____________________ Date of birth ____________ Marital status: S M W Sep I

City ____________________ State ________ Zip ________

Telephone: Home ____________________ Office ____________________

Referred by ____________________

Spouse's name ____________________

Spouse's employer / address ____________________

Emergency contact ____________________ Tel# ____________ Relationship ____________

PATIENT EMPLOYER INFORMATION

Employer name ____________________ Tel# ____________________

Employer street address ____________________ City / State ____________ Zip ________

Patients occupation ____________________

INSURED PERSON (IF NOT PATIENT)

Name ____________________ Tel# ____________________

Street Address ____________________ City / State ____________ Zip ________

Relationship to patient ____________________

INSURANCE

Medicaid # (if applicable) ____________________ Medicare # (if applicable) ____________

Primary Insurance Company Name ____________________

ID # ____________________ Group # ____________ Tel.# ____________

Secondary Insurance Company Name ____________________

ID # ____________________ Group # ____________ Tel.# ____________

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of thi: authorization to be used in place of the original.

Date ____________________ Signature ____________________

I hereby authorize Dr. ____________________ to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Dr. ____________________ (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date ____________________ Signature ____________________
(Patient, parent, or guardian)

MISCELLANEOUS NOTES

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KURT D JONES, MD, FACOG CENTER FOR WOMENS HEALTH

Triple i / CliniFo[rm]

PATIENT REGISTRA[TION]

Name ______________________ SS# ______________

GENERAL MEDICAL INFORMATION

Describe the current medical problem/reason for today's visit: ______________

Present medications: ______________

Allergies to medications: ______________

Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent: ______________

Other physicians currently treating you: ______________

Previous or other medical problems: ______________

List any previous surgeries or hospitalizations (include number of miscarriages and live births): ______________

Females only: Are you pregnant, planning a pregnancy or nursing a child? ☐ Yes ☐ No

Do you smoke? ☐ No ☐ Yes ☐ Cigarettes ☐ Pipe ☐ Cigars No. of years ________ How much? ________

Interested in stopping? ☐ Yes ☐ No

Do you regularly drink alcohol? ☐ Yes ☐ No How many ounces/beers per day? ________

Do you regularly drink coffee? ☐ Yes ☐ No How many cups per day? ________

Are you under a lot of pressure at work? ☐ Yes ☐ No Please describe: ________

PERSONAL MEDICAL HISTORY

Have you ever had any of the following (check all that apply):

☐ Chest pain/pressure/tightening ________
☐ Hypertension ________
☐ Heart attack ________
☐ Stroke ________
☐ Headaches ________
☐ Glaucoma ________
☐ Allergies or Eczema ________
☐ Depression ________
☐ Blood in stool ________
☐ Asthma ________
☐ Dizzy spells ________
☐ Cancer ________
☐ Diabetes ________
☐ Arthritis ________
☐ Difficulty hearing ________
☐ Glaucoma ________
☐ Memory loss ________
☐ Hemorrhoids ________
☐ Kidney disease ________
☐ Shortness of breath ________
☐ TB/Lung disorder ________
☐ Ulcers ________
☐ Skin disorders ________
☐ Hepatitis ________
☐ Cataracts ________
☐ Digestive problems ________
☐ Frequent urinary infections ________

☐ Other: ______________

IMMUNIZATIONS

(Year last received, if known)

Smallpox ________

Tetanus ________

Typhoid ________

Polio ________

Influenza ________

Pneumonia ________

bella ________

Hepatitis ________

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	C[HILDREN]
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	
EPILEPSY	☐	☐	☐	☐	☐	
CANCER	☐	☐	☐	☐	☐	
ECZEMA / PSORIASIS	☐	☐	☐	☐	☐	
HEART ATTACK / STROKE	☐	☐	☐	☐	☐	
DIABETES	☐	☐	☐	☐	☐	
ASTHMA	☐	☐	☐	☐	☐	
HAY FEVER	☐	☐	☐	☐	☐	

MISCELLANEOUS NOTES

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Interested in stopping? ❑ Yes ❑ No

Do you regularly drink alcohol? ❑ Yes ❑ No How many ounces/beers per day? ________

Do you regularly drink coffee? ❑ Yes ❑ No How many cups per day? ________

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Have you ever had any of the following (check all that apply):

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❑ Asthma ________
❑ Kidney disease ________
❑ Hypertension ________
❑ Dizzy spells ________
❑ Shortness of breath ________
❑ Heart attack ________
❑ Cancer ________
❑ TB/Lung disorder ________
❑ Stroke ________
❑ Diabetes ________
❑ Ulcers ________
❑ Headaches ________
❑ Arthritis ________
❑ Skin disorders ________
❑ Glaucoma ________
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❑ Digestive problems ________
❑ Blood in stool ________
❑ Hemorrhoids ________
❑ Frequent urinary infections ________
❑ Other: ________

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HIGH BLOOD PRESSURE	❑	❑	❑	❑	❑	
EPILEPSY	❑	❑	❑	❑	❑	
CANCER	❑	❑	❑	❑	❑	
ECZEMA / PSORIASIS	❑	❑	❑	❑	❑	
HEART ATTACK / STROKE	❑	❑	❑	❑	❑	
DIABETES	❑	❑	❑	❑	❑	
ASTHMA	❑	❑	❑	❑	❑	
HAY FEVER	❑	❑	❑	❑	❑	

MISCELLANEOUS NOTES

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