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

GYNECOLOGIC ONCOLOGY ASSOCIATES

PATIENT NAME_____
STREET ADDRESS_____
CITY, STATE, ZIP_____
HOME PHONE: _____WORK PHONE: _____
CELL PHONE: _____DATE OF BIRTH: _____
SOCIAL SECURITY NUMBER: _____
EMPLOYER: _____
EMERGENCY CONTACT: _____ PHONE #_____
REFERRING PHYSICIAN_____
IF YOU ARE ON YOUR PARENT'S OR SPOUSE'S INSURANCE, PLEASE COMPLETE THE INFORMATION BELOW.
CIRCLE THE ONE THAT APPLIES:
PARENT / SPOUSE NAME: _____
PARENT/SPOUSE EMPLOYER: _____
PARENT/SPOUSE BUSINESS PHONE: _____
DATE OF BIRTH:_____SOC.SECURITY #_____

PRIMARY INSURANCE DATA

PLAN NAME_____
MAILING ADDRESS_____
CITY, STATE, ZIP _____
PHONE NUMBER: _____EFFECTIVE DATE: _____
POLICY NUMBER: _____GROUP NUMBER: _____
POLICY HOLDER: _____DATE OF BIRTH: _____
HMO(Y/N) _____PPO (Y/N) _____CO PAY$ _____
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 it agents or Insurance Company any information needed to determine these benefits payable for related service. I understand that I am responsible for any amount not covered by insurance.
Signature _____

Gynecologic Oncology Associates

Date _____

Name _____Age_____

Marital status _____Occupation_____

Reason for visit: _____

_____

_____

_____

_____

_____

_____

_____

GYNECOLOGIC HISTORY:

Last menstrual period: _____Age at First Period_____

How long between cycles_____Days duration _____

Pain/Cramps: No _____Mild _____Severe _____

When was your last pap smear? _____Result _____

Have you ever had an abnormal pap smear? No _____Yes _____

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 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 had had:

Year Hospital Procedure

_____
_____
_____
_____
_____

Please list any hospitalizations for medical illness

Year Hospital Procedure

_____
_____
_____
_____
_____

Are you under another doctor's care?

Doctor Medical Problem

_____
_____
_____

Current Medications: (Prescriptions, over-the-counter medicines, vitamins, supplements, herbal medicines) (Include aspirin, hormones, etc.)

Medication	Dose/How often	Purpose	How long?	Problems or comments	Prescribing Doctor

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 diseases that run in the family? _____
_____
_____
_____