Patient Demographic

Date:

Patient ID: Preferred Provider:

Patient Name:

Address:

City: State: Zip Code:

Home Phone: Work Phone:

Cell Phone:

Date of Birth: Social Security Number:

Marital Status: Employer:

Pharmacy: RX Phone Number:

Race: Ethnicity:

Referred By: Primary Care Provider

INSURANCE INFORMATION

Primary Insurance Plan: Insured's DOB:

Insurance Address:

City: State: Zip Code:

Policy Number: Group Number:

Insured's Name: Patient Relation to Insured:

Secondary Insurance Plan: Insured's DOB:

Insurance Address:

City: State: Zip Code:

Policy Number: Group Number:

Insured's Name: Patient Relation to Insured:

CONSENT FOR TREATMENT/INSURANCE AUTHORIZATION & ASSIGNMENT

I hereby authorize my physician to release any and all information acquired in the course of my examination or treatment to my insurance carrier.

I hereby assign/authorize payment directly to the physician for the medical and/or surgical benefits otherwise payable to me for services provided. I understand that I am financially responsible for the charges not covered/allowed by my insurance. A photocopy of this authorization shall be accepted as the orginal.

Signature: ______________________________ Date: ____________

HIPAA CONSENT FORM
Thunderbird Obstetrics & Gynecology, Ltd.
5757 W. Thunderbird Road, Suite W202
Glendale, AZ 85306

Please read this form carefully as our office will only speak to the persons you name below in regard to the health, billing, or scheduling information we collect about you. Keep in mind that if you check "I elect not to give consent...," we will not speak to anyone, including family members, friends, etc. who call for information. Remember that under the HIPAA privacy rule as outlined in our Privacy Policy, we do have the right to disclose medical information to certain individuals to aid in the continuity of your care.

Patient's Name: ____

Patient's Date of Birth: ________________________ **Account #** ______________

HOW ARE WE AUTHORIZED TO CONTACT YOU?
(Check all that apply)

HOME PHONE	CELL PHONE	WORK PHONE
( )	( )	( )
☐ Leave call back number only	☐ Leave call back number only	☐ Leave call back number only
☐ Okay to leave detailed message	☐ Okay to leave detailed message	☐ Okay to leave detailed message

CHOOSE ONE OPTION BELOW:

☐ **I give the following individual(s) my consent** to call or act on my behalf. This consent is restricted to the options I have selected. If at any time I wish to change the individual(s) listed below, I am aware that I must notify the office in writing by completing a new consent form. **This consent is valid until we are notified by the patient of a change.**

Name(s): ______________________ Relationship: ______________________

Phone: ______________________ Alternate phone: ______________________

Name(s): ______________________ Relationship: ______________________

Phone: ______________________ Alternate phone: ______________________

*** For additional persons, please continue on back of form or attach 2nd form.**

Please mark only one box:

- ☐ All information (Treatment & Medication information, Lab & Radiology results, Appointments, Billing)
- ☐ Only Lab/Radiology results & Medications
- ☐ Only Appointments & Billing
- ☐ Other : ____

☐ **I elect not to give consent** for any individual(s) to call or act on my behalf. Any information pertaining to my treatment, lab & radiology results, medications, billing, or other information should only be disclosed to me. If at any time, I wish to add individual(s) to call or act on my behalf, I am aware that I must notify the office in writing by completing a new consent form.

Patient Signature: ________________________________ **Date:** ______________

Thunderbird Obstetrics and Gynecology, Ltd.
Confidential Medical History

Name ______________________________ Birthdate_________ Age _____ Date____________

Allergies to medications/food/environment	Reaction

Current Medications (Prescription, over the counter, herbal)	Prescribing Doctor	Dose	Instructions	Reason Used

What do you do so you don't become pregnant?

_____ Diaphragm _____ Condoms _____ Sponge _____ Rhythm _____ IUD
_____ Withdrawal _____ Depo Provera _____ Vasectomy _____ Norplant _____ Pills
_____ Essure _____ Tugal Ligation _____ Implanon _____ Ortho Evra _____ Nuva Ring
_____ Other ____

First day of last period______________________________
What age were you when you started your first period? ____________
Are your periods regular? ________________
Is there bleeding between periods? ___________
How often do your cycles occur? ________________________
For how many days do you bleed? ________________________
Flow is: ______ scant ______ mild ______ mod ______ severe ______ incapacitating
Other symptoms with periods? ____
____

Date of last pap smear ________________________________
Have you had an abnormal pap smear? No ______ Yes_____
Has this been treated? No ______ Yes_____
How? ____
Do you examine your breasts regularly? No ______ Yes_____
When was your last Mammogram (if any)? __________________ Result _________________________
Do you have concerns about your breasts? ____
When was your last Bone Density (if any)? __________________ Result _________________________

Thunderbird Obstetrics and Gynecology, Ltd.
Confidential Medical History

Name ________________________________ Birthdate_________ Age _____ Date____________

Past Medical / Surgical History (Including Injuries)

Condition/Disease	Date	Treatment

Have you had: Pain with intercourse? No ___ Yes___
Bleeding with intercourse? No ___ Yes___
Concerns about vaginal discharge? No ___ Yes___ Explain ___________________________
Leaking of urine? No ___ Yes___ Explain ___________________________
Pelvic infections? No ___ Yes___ Explain ___________________________
Sexually transmitted diseases? No ___ Yes___ Explain ___________________________

Total number of pregnancies

Full Term	Premature	Cesarean Section	Vaginal Delivery	Ectopic	Miscarriage	Abortion	Stillborn	Live at Birth	Live at Present

Pregnancy Details

Preg #	Sex	Month/ Year	Number of weeks	Weight	Hrs of Labor	Delivery Type	Obstetrical/Neonatal Problems	Delivery Doctor

Thunderbird Obstetrics and Gynecology, Ltd.
Confidential Medical History

Name ________________________________ Birthdate_________ Age _____ Date___________

Family History

Please complete if any of your close relatives have had any of the following:

Disease	Circle Yes/No	Family Member	Family Members 1st Name	Age of Onset	Age of Death	Cause of Death (Circle)
Cancer of Breast	Yes No					Yes No
Cancer of Ovary	Yes No					Yes No
Cancer of Uterus	Yes No					Yes No
Cancer of Cervix	Yes No					Yes No
Cancer of Colon	Yes No					Yes No
Diabetes	Yes No					Yes No
Tuberculosis (TB)	Yes No					Yes No
Heart Disease	Yes No					Yes No
High Blood Pressure	Yes No					Yes No
Other:						Yes No
						Yes No
						Yes No
						Yes No
						Yes No

Social History

Primary Language Spoken______________________________ Race_______________________
Do you smoke? No_____ Yes_____ If yes, type of tobacco?_____________ Number of years_____ Pks/day_____
Do you drink alcohol? No_____ Yes_____ If yes, type of alcohol___________________________________
How often?_____________________ Amount___________________ Last drink_____________________
Do you consume caffeine? No_____ Yes_____ If yes, what kind?_____________ Amount________________
Do you use recreational drugs? No_____ Yes_____ If yes, what kind?____________________________
Do you have a regular exercise program? No_____ Yes_____ Hours/week__________________________
How many sexual partners do you have? None_____ One_____ 2-5_____ 5+_____
Have you been exposed to sexual or physical violence or abuse? No_____ Yes_____
Are there animals in the home? No_____ Yes_____ If yes, what kind?____________________________
Is the patient the individual who cleans up after the animals? No_____ Yes_____
If medically necessary, would you agree to a transfusion? No_____ Yes_____

Revised 2/8/2011