CONFIDENTIAL PATIENT INFORMATION
ELIZABETHTOWN PHYSICIANS FOR WOMEN, PSC

(Please Print in Black Ink)

1115 Woodland Dr.
Elizabethtown KY 42701
270-769-5963
www.etownobgyn.com

Name (last) (first) (middle) ____ Maiden ____ Birthday ____
Address ____ Cell Phone( ) ____ Hm. Phone( ) ____ Age ____
City ____ State ____ Zip code ____ (Marital Status) M W S D
E-mail Address ____ S.S. No ____
Religion ____ Race ____ Referred By ____
Employer ____ Occupation ____ Wk. Phone( ) ____ Yrs. ____
Address ____ City ____ State ____ Zip Code ____
Employment Status: ❑Full Time ❑Part Time ❑Unemployed ❑Disabled ❑Self-Employed ❑Retired Date of retirement ____
Insurance Co. Name ____ ID# ____ Group # ____
Policyholder Name ____ DOB ____ Relationship ____
Policy Holders Employer Name/Address ____ Wk. Phone ( ) ____
City ____ State ____ Zip code ____ Effective Date for this ins. ____
2nd Insurance Co. Name ____ ID# ____ Group # ____
Policyholder Name ____ DOB ____ Relationship ____
Policy Holders Employer Name/Address ____ Wk. Phone ( ) ____
City ____ State ____ Zip code ____ Effective Date for this ins. ____
Spouse's Name ____ DOB ____ S.S. No. ____
Spouse's Cell ( ) ____ Spouse's Work No.( ) ____
Emergency Contact (Other than Spouse) ____ Relationship ____ Phone# ____
Please list all drug allergies ____
Other Physicians managing your care: ____
Family Physician ____ Phone# ____
Preferred Pharmacy ____ Phone# ____
Does your insurance plan cover annual preventive wellness exams ❑ yes ❑ no ❑ unsure
Please check one, are you here for a ❑Yearly Exam ❑ Problem Visit ❑Pregnancy

We will fill out up to 1 form for a Hospitalization and/or Surgical Procedure at no cost to you. There will be a $25.00 charge to complete each additional form and/or forms for routine office visits.

As part of medical procedures or tests, I understand that I will be tested for human immunodeficiency virus (HIV) infection, hepatitis, or any other blood-borne infectious disease if my doctor orders such testing for diagnosis purposes, and I consent to all such testing.

I hereby authorize and direct my insurance carrier to pay directly to the undersigned physician any benefits due my insurance plan(s); authorize the undersigned physician to release any information acquired in the course of my care; to release any information requested by my insurance company or its representative.

I hereby assign to Elizabethtown Physicians for Women all money to which I am entitled for medical and/or surgical expenses relative the service rendered, but not to exceed my indebtedness to Elizabethtown Physicians for Women.

I understand that I am financially responsible to Elizabethtown Physicians for Women for charges not covered by this assignment. The undersigned waives all rights of exemption under the laws of the state.

I agree to pay all collection costs of no less than 30% and court costs and reasonable attorney fees if I fail to promptly pay this account when due and turned over to collection service.

I consent to treatment as necessary or desirable to the care of the patient first named above. I acknowledge full responsibility to pay for this treatment. Payment is due at the time of service, as are co-payments and deductibles, unless prior arrangements are made. If we do not receive payment from your insurance company within 30 days, we ask that you contact them to get your bill paid.
ALL CHARGES WILL BECOME THE PATIENTS RESPONSIBILITY IF YOUR INSURANCE HAS NOT PAID WITHIN 60 DAYS.

Signed (Patient, Parent or Agent) ____ Date ____

OPERATIONS / HOSPITALIZATIONS

OPERATION	DATE	HOSPITAL / DOCTOR

Name ____DOB _______________________ Date_________________________

OBSTETRIC HISTORY

	Number		Number		Number
Pregnancies		Live Births		Miscarriages	
Premature Birth(<37 weeks)		Living Children		Abortions	

NO.	Date of Birth	Wt. at birth	Baby's Sex	Weeks Pregnant	Type of Delivery	Complications?
1			Male / Female		Vaginal / C-section	
2			Male / Female		Vaginal / C-section	
3			Male / Female		Vaginal / C-section	
4			Male / Female		Vaginal / C-section	

PERSONAL PAST HISTORY OF ILLNESS

Major Illness	YES	NO	Major Illness	YES	NO	Major Illness	YES	NO
Asthma			Stroke			Blood Transfusions		
Pneumonia / Lung Disease			Rheumatic Fever			Seizures / Epilepsy		
Kidney Infection / Stones			Blood Clots in Lungs / Legs			Bowel Problems/IBS/Spastic Colon		
Tuberculosis			Eating Disorder			Glaucoma		
STD's / HIV/ AIDS			Lupus			Cataracts		
Migraines			Cancer			Arthritis, Joints, Back Problem		
High Blood Pressure			Ulcer, Reflux, Hernia			Hepatitis / Liver Disease		
Heart Trouble			Depression / Anxiety			Thyroid Disease		
Diabetes			Anemia					
Elevated Cholesterol			Abnormal Pap Smears / HPV					

Physicians Notes

SOCIAL HISTORY

	YES	NO
Do you smoke? Packs per day ___ Year(s) ___	❑	❑
Ex-smoker? Packs per day ___ Year(s) ___	❑	❑
Alcohol: Drinks per week ___ Year(s) ___	❑	❑
Recreation, drug use	❑	❑
Age of first sexual intercourse _____________		

	YES	NO
Seat belt use	❑	❑
Regular Exercise	❑	❑
Take calcium supplement	❑	❑
Sexually abused or hurt by someone	❑	❑
Number of sexual partners during your lifetime ___________		

FAMILY HISTORY

	YES	NO	Physicians Notes
Heart Disease	❑	❑	
Elevated cholesterol	❑	❑	
Hypertension	❑	❑	
Diabetes	❑	❑	
Osteoporosis	❑	❑	
Blood clots in lungs/legs	❑	❑	

	YES	NO	Physicians Notes
Breast cancer	❑	❑	
Ovarian cancer	❑	❑	
Uterine cancer	❑	❑	
Colon cancer	❑	❑	
Lung cancer	❑	❑	
Misc. cancer	❑	❑	

Name ____DOB _____________________ Date ________________________

REVIEW OF CURRENT SYMPTOMS

Mark (X) all that apply   If no marks system is negative.

Constitutional		**Genitourinary**		**Breasts**	
Recent weight loss/gain	❑	Abnormal Pap Smear	❑	Pain in breasts	❑
Fatigue	❑	Abnormal bleeding	❑	Nipple Discharge	❑
Eyes		Painful periods	❑	Lumps	❑
Vision Change	❑	Painful intercourse	❑	**Neurologic**	
Contacts / Glasses	❑	Abnormal vaginal discharge	❑	Dizziness	❑
Ears, Nose, Throat		Difficulty becoming pregnant	❑	Seizures	❑
Hearing	❑	PMS	❑	Numbness	❑
Sinus problems	❑	DES exposure	❑	Frequent severe headaches	❑
Mouth Sores	❑	Blood in urine	❑		❑
Cardiovascular		Pain with urination	❑	**Psychiatric**	
Chest Pain	❑	Frequent	❑	Depression or crying episodes	❑
Difficulty breathing with exertion	❑	Involuntary loss of urine	❑	Severe anxiety	❑
Swelling of Feet / legs	❑	Urine Loss with coughing	❑	Sleep problems	❑
Rapid of irregular heartbeat	❑	Urine loss if can't go quickly	❑	Panic attacks	❑
Heart murmur	❑	**Musculo Skeletal**		**Endocrine**	
Varicose veins	❑	Muscle weakness	❑	Hair loss	❑
Respiratory		Muscle or joint pain	❑	Heat / Cold intolerance	❑
Wheezing	❑	**Skin**		Abnormal thirst	❑
Spitting up blood	❑	Unwanted hair	❑	Hot flashes	❑
Shortness of breath	❑	Black or enlarging moles	❑	**Hematologic / Lymphatic**	
Chronic cough	❑			Cuts do not stop bleeding	❑
Gastrointestinal				Enlarged lymph nodes	❑
Frequent Diarrhea	❑			**Allergic / immunology**	
Bloody stool / Rectal bleeding	❑			Medication allergies	❑
Nausea /Vomiting	❑				
Constipation	❑				
Involuntary loss of stool	❑				

Physicians Notes

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Are your immunizations up to date? ❑YES ❑NO ________________________________

Do you do self breast exams? ❑Never ❑Sometimes ❑Monthly

If using birth control, which method? ❑Birth control pills ❑Foam ❑Condoms ❑Depo-Provera

❑Birth control patch ❑Birth control ring ❑Nexplanon ❑IUD ❑Withdrawal ❑Vasectomy ❑Tubal Ligation

If age 50 or older, have you had:

A. Sigmoidoscopy or colonoscopy in past 5 years ❑Yes ❑No
B. Bone Density Test (Test for Osteoporosis) ❑Yes ❑No