PATIENT INFORMATION FORM

Patient's last name: ______________________________ **First name:** ______________________ **Middle initial:** ______

DOB: __________ **Age:** ______ **Social Security #:** _____________________ Female ____ Male ____ Transgender ____

Address: ____ **Apt/Unit #:** _____________________

City: __________________________ **State:** _______ **Zip code:** ___________ **Home phone #:** _____________________

Cell Phone #: ______________________ **Email Address:** ____

Preferred method of contact: (Please check all that apply) Home Phone _____ Cell Phone _____ Email _____

Relationship status: (Please check one) Never Married _______ Single _______ Married/Domestic Partner _______

Separated ______ Divorced _______ Widow _______ Other (Please list)_________________________________

Race: (Please check all that apply) White ______ American Indian ______ Black or African American ______ Asian ______

Native Hawaiian or other Pacific Islander ______ Other ___________________________ Decline to state ______

Ethnicity: (Please select only one) Hispanic/Latino ______ Non-Hispanic/Non-Latino _______ Declines to state _______

Occupation: _____________________ **Employer:** __________________________ **Phone number:** _________________

How did you hear about us? (Circle one) Referred by Doctor Family/Friend Search engine Other

Emergency contact: _________________________ **Phone number:** __________________ **Relationship:** ____________

Were you referred by another facility? Name of Doctor/Facility: _____________________ **Phone #:** _______________

INSUREANCE INFORMATION

Primary Insurance: (If you have a secondary insurance, please provide the front desk both cards)

Person responsible for insurance: ___________________________ Relationship to patient: _____________________

DOB: ______________ Social Security #: ________________________ Phone #: ______________________________

Name of Insurance: _____________________ ID/Policy #: ________________________ Group #: _______________

Insurance Company's address: ____ City: _____________________

State: ________ Zip code: ______________ Phone number#: ______________________

Most Insurance carriers require us to submit claims for patient services. For this reason, we request all patients to fill out completely and sign registration form on an annual basis to keep our records current. Thank you for your cooperation. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Physician. I understand that I am financially responsible for any balance. I also authorize Desert Star Family Planning or insurance company to release any information required to process my claims.

____ ______________________

Patient Signature: **Date:**

____ ______________________

Signature of Parent or Legal Guardian, if applicable: **Date:**

Office Use Only

Type of Identification/Number: _____________________________ Staff initials: ______________ Date: _________________

MEDICAL HISTORY

Print Patient Name: ____ Date of Birth: _________________

MEDICAL HISTORY Have you **EVER** had any of the following: (**Please complete BOTH columns.**)

Past/Now/Never	Condition
☐☐☐	**Anemia**
☐☐☐	**Anxiety**
☐☐☐	**Bleeding Problems**
☐☐☐	**Blood Transfusion**
☐☐☐	**Deep Vein Thrombosis**
☐☐☐	**Pulmonary Embolism (PE) or Blood Clotting Disorders**
☐☐☐	**Long-term Steroid Medication Use** (e.g., prednisone)
☐☐☐	**Genital Herpes** Last outbreak: ______/______/______

Past/Now/Never	Condition
☐☐☐	**Stroke**
☐☐☐	**Seizures or Epilepsy**
☐☐☐	**Bowel Disease** (e.g. IBS, Crohn's, Celiac)
☐☐☐	**Thyroid Disease**
☐☐☐	**Bladder Infection**
☐☐☐	**Sickle Cell Disease**
☐☐☐	**Depression**
☐☐☐	**Uterine Abnormalities or Fibroids**

Past/Now/Never	Condition
☐☐☐	**Cancer** – *If yes, what?* ____
☐☐☐	**Cardiovascular**: Irregular heartbeat, severe chest pain not resolved with antacids, heart disease, heart attack or serious heart valve problem
☐☐☐	**Chest/Breast**: Lump, constant pain, or nipple discharge – *If yes, describe:* _________________________
☐☐☐	**Chlamydia, Gonorrhea, Pelvic Inflammatory Disease (PID) or other sexually transmitted infection**
☐☐☐	**Elevated Blood Pressure**
☐☐☐	**Endocrine**: Excessive thirst or night sweats
☐☐☐	**Gastrointestinal**: Ongoing nausea or severe abdominal pain, change in bowel movements
☐☐☐	**Genitourinary**: Abnormal discharge – *If yes, describe:* ______________________________________
☐☐☐	**Genitourinary**: Itching or irritation of genital area
☐☐☐	**Genitourinary**: Pain or bleeding with sexual activity
☐☐☐	**Genitourinary**: Pain/burning or bleeding with urination
☐☐☐	**Genitourinary**: Severe pain with periods that may include nausea, vomiting, or interfere with school or work
☐☐☐	**Kidney Disease or Kidney Failure or Chronic Adrenal Failure**
☐☐☐	**Lymph**: Painful or swollen glands in your groin
☐☐☐	**Mouth**: Bumps or sores in the mouth – *If yes, describe*: ______________________________________
☐☐☐	**Neurological**: Migraine OR an increase or change in headaches
☐☐☐	**Psychosocial**: Difficulty sleeping, eating, going to work or school for greater than 3 weeks
☐☐☐	**Respiratory**: Difficulty breathing with exercise, Asthma, breathing problems, other lung disease (e.g., sleep apnea) / Inhaler use
☐☐☐	**Skin**: Rashes or lesions, bumps, sores – *If yes, describe*: ______________________________________
☐☐☐	**Other serious medical problems, illness, hospitalizations, surgeries, blood transfusions or exposure to blood products** *If yes, explain:* ______________________________________
☐☐☐	Any **CURRENT/ONGOING** medical problem being managed by another health care provider or any **PLANNED UPCOMING** major surgeries *If yes, explain:* ______________________________________

Past/Now/Never

☐☐☐ **Any PAST Surgeries?** *If yes, what* and when: ____

☐☐☐ **Any Hospitalization(s)?** *If yes, when and for what and when*: ____
____

SOCIAL HISTORY

Past/Now/Never

☐☐☐ **Do you smoke cigarettes / cigars or chew tobacco?** *If yes, how may/much do you smoke/chew a day?*____

☐☐☐ **Do you drink alcohol?** *If yes, how often and how much:* ____________________________________

☐☐☐ **Have you ever used street or IV drugs or other substances**? ________________________________
*If yes, please list types and last use dates:*____

Do you feel **Safe** at Home? ☐ No ☐ Yes ____***WE CAN HELP!***

Do you have **concerns** regarding **Domestic Violence?** ☐ No ☐ Yes __________________________***WE CAN HELP!***

Do you have any allergies to medications, metals, latex, medications (including antibiotics/pain reducers), shellfish, or antiseptic solutions (iodine/alcohol/Hibiclens)?☐ No ☐ Yes

If yes, list allergy and reaction: ____

Are you currently taking any medications, drugs, over-the-counter or herbal medications, vitamins or mineral supplements? ☐ No ☐ Yes

If yes, please list: ____

FEMALE PATIENTS ONLY – Please complete the last three sections

MENSTRUAL HISTORY

When was the first day of your last normal menstrual period? ____/____/____

Age that you first started your period: _________________

Was your last period normal? ☐ No ☐ Yes *If **no**, explain*: _______________________________________

Do you have problems with your period? ☐ No ☐ Yes *If **yes**, explain*: _____________________________

Month/year of last pap smear: ____/____

Have you ever had an abnormal pap smear, colposcopy, cryotherapy, or LEEP? ☐ No ☐ Yes

CONTRACEPTIVE HISTORY

Are you interested in getting birth control today? ☐ No ☐ Yes *If **yes**, what:* __________________________

What birth control method are you currently using? ____

Any problems with this method? ☐ No ☐ Yes *If **yes**, explain:* ___________________________________

What methods have you used in the past? ____

Any problems with your previous methods? ☐ No ☐ Yes *If **yes**, explain*: __________________________

PREGNANCY HISTORY

Number of: **Pregnancies**___ **Vaginal deliveries**___ **C-sections**___ **Miscarriages**___ **Abortions**___ **Ectopic (tubal)**___

When did your last pregnancy end? ____/____/____ Any complications? ______________________________

Are you breastfeeding now? ☐ No ☐ Yes

Patient Signature: ____ **Date:** ______/______/_______

For Office Only

Staff Signature: ____ **Date:** ______/______/________