

Northpointe

Obstetrics & Gynecology, P.C.

Competent, compassionate health care for women.

WELCOME TO OUR OFFICE

Appointment Date: _____

Name _____

Birthdate _____ Marital Status _____ Maiden Name _____

Address _____ City _____ State _____ ZIP _____

Phone # _____ Work or Message Phone _____

If a child, parent's or guardian's name _____

Patient's Employer _____ Occupation _____

Social Security # _____ Driver's License # _____

Do you have Medical Insurance: Yes or No _____ If no, how do you intend to pay? _____

Subscriber Name _____ Subscriber Birthdate _____

Subscriber's Employer _____ Subscriber's Social Security # _____

Please provide receptionist with all your insurance cards

Insurance Co. Name _____ Address _____

Insurance Group: _____ Contract: _____

Additional Numbers: _____

Person financially responsible for this account? _____

Address _____ Phone: _____

In case of an emergency, please contact _____ Phone _____

Who may we thank referring you? _____

What will you be seen for today? _____

Were records sent from another health care provider? _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize NORTHPOINTE OB/GYN to release to my insurance company or other physicians upon my request any information regarding my treatment or diagnosis of my condition that they consider appropriate to obtain payment for service rendered to me. I also authorize and request such payments be made directly to Northpointe Ob/Gyn for any amounts due for such medical services. I understand that I am financially responsible for all charges whether or not paid by insurance.

NORTHPOINTE NO SHOW/CANCELLATION POLICY

Any patient that misses or cancels her appointment (the day of her appointment) three (3) times will be discharged from our practice and will be asked to seek care elsewhere.

I UNDERSTAND AND AGREE WITH THE ABOVE STATEMENTS AND POLICY

Patient's Signature _____ Date _____

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PRESENT MEDICATIONS (Include birth control pills and over the counter medications)

MEDICATION	DOSE	HOW OFTEN

DRUGS YOU ARE ALLERGIC TO:

MEDICATION	REACTION (WHAT HAPPENED WHEN TAKEN)

OPERATIONS YOU HAVE HAD:

OPERATION	SURGEON	YEAR

HABITS

YES NO

Do you or did you ever smoke cigarettes?			How many packs per day?
Do you drink alcohol?			How many drinks per day?
Do you or did you ever use street drugs?			What drugs?
Do you regularly drink coffee?			How many cups per day?

FAMILY HISTORY (List known conditions and diseases of any blood relative in your immediate family. Also include mental retardation and birth defects.)

CONDITION	RELATIONSHIP

