REGISTRATION

(PLEASE PRINT)

SS# WIFE _____

SS# HUSBAND _____

Date: _____ Home Phone: _____

PATIENT INFORMATION

Name _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Suscriber # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Suscriber # _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____

Reason for visit: _____

_____

GYNECOLOGICAL HISTORY

Check (✓) problems you have or have had in the past:

☐ Abnormal Pap smear	☐ Extreme menstrual pain	☐ Painful intercourse
☐ Bleeding between periods	☐ Hot flashes	☐ Urinary problems
☐ Bleeding with intercourse	☐ Irregular periods	☐ Vaginal discharge
☐ Breast lump	☐ Nipple discharge	☐ Vaginal infections

Age your menstrual periods began _____ Date of last menstrual period _____

How often do periods occur? _____ How long do they last? _____ How many days of heavy flow? _____

Are you sexually active? ☐ Yes ☐ No More than one partner? ☐ Yes ☐ No

Date of your last Pap smear _____ Result _____

Date of last mammogram _____ Result _____

BIRTH CONTROL METHOD	YEARS USED	PROBLEMS/REASONS DISCONTINUED

PLEASE FILL OUT BACK PAGE COMPLETELY.

(OVER)

PREGNANCIES

Year	Hospital/Doctor	Complications	Sex of Child	Weight of Child

Number of children now living _____ Number of miscarriages/stillbirths _____ Number of abortions _____

GENERAL MEDICAL HISTORY

CONDITIONS Check (✓) conditions you or your family member have or have had in the past. Explain.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gall Bladder Disease
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pelvic Infection
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Uterine Abnormalities
- ☐ Venereal Disease
- ☐ Other_____

_____

_____

HOSPITALIZATIONS (For other than childbirth)

Year	Reason for Hospitalization and Outcome	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, please give approximate dates: _____

CURRENT MEDICATIONS

_____

_____

_____

Pharmacy Name _____

ALLERGIES

_____

_____

_____

ASSIGNMENT AND RELEASE

I certify that the above information is correct to the best of my knowledge. I, the undersigned, certifiy that I have insurance coverage with _____ and assign directly to EVELINE ASSAD, M.D., LLC

Name of Insurance Company (ies)

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

_____ _____

Patient Signature Date

_____ _____

Reviewed By Date