

**PATIENT INFORMATION**

Today's Date: \_\_\_\_\_

*(Please Print Clearly)*

Name: (First, Middle Initial, Last) \_\_\_\_\_

Address: \_\_\_\_\_

Street, Apt # City State Zip

Home Phone Number: \_\_\_\_\_ Cell Number (If Applicable): \_\_\_\_\_

Emergency Number: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Religion: \_\_\_\_\_

Name of your Primary Care Physician \_\_\_\_\_ Phone Number: \_\_\_\_\_

**PATIENT'S EMPLOYMENT**

Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Street City State Zip x \_\_\_\_\_

**SPOUSE'S INFORMATION**

Spouse's Name: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Street City State Zip

Who Referred You To This Office: \_\_\_\_\_

*(This reference is for office use only)*

**MEDICAL INSURANCE INFORMATION**

Please give your card to receptionist for photocopy and/or insurance form if applicable

**INSURANCE INFORMATION**

Insurance Company Name or Hub (IPA): \_\_\_\_\_ Phone: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Effective date: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Effective date: \_\_\_\_\_

**RESPONSIBLE PARTY**

Please complete the following if someone other than you the patient or your spouse is responsible for this bill, example: Child, Dependent -

Guarantor's Name: \_\_\_\_\_ Relationship to the Patient: \_\_\_\_\_

Address of Guarantor: \_\_\_\_\_ DOB: \_\_\_\_\_

Street City State Zip

Home Phone Number: \_\_\_\_\_ Business Phone Number: \_\_\_\_\_

Employed By: \_\_\_\_\_

Signature of Guarantor of Payment: \_\_\_\_\_ Date: \_\_\_\_\_

# RECORD OF PERSONAL HISTORY

Today's Date

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_  
Are you here for a routine check up?  Yes  No If you have any medical problems at this time please state: \_\_\_\_\_

## PAST HISTORY

Have you ever had any operations such as tonsillectomy, hysterectomy, etc., ? List WHEN, WHERE, & WHAT Type of Surgery:

## MEDICAL HISTORY

Mark an "X" in the Appropriate Response

	YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
DES Child	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

Explanation of above: \_\_\_\_\_

## SKIN

(Circle Y=Yes N=No)

Prolonged bleeding from cuts? Y N  
Blood clots in legs? Y N

## EYES

Wear glasses or contact lenses? Y N

## EARS

Difficulty in Hearing? Y N  
Ringing in the Ears? Y N  
Frequent Dizzy Spells? Y N

## NOSE, MOUTH, THROAT

Frequent Nose Bleeds? Y N  
Wear Dentures? Y N  
Frequent Sore Throats? Y N  
Hay fever or Allergies? Y N

## CHEST

Ever had high blood pressure? Y N  
Heart trouble, murmur, or pain? Y N  
Sever shortness of breath? Y N  
Chronic cough? Y N  
Ever cough up blood? Y N  
Ankle swelling? Y N  
Heart often skips a beat or race? Y N

## GASTROINTESTINAL

Chronic Constipation or Diarrhea? Y N  
Recent Change in Bowel Habits? Y N  
Bloody or Tarry stools? Y N  
Gallbladder disease, ulcer, jaundice, colitis? Y N

## URINARY TRACT

Ever had Kidney or Bladder Infections? Y N  
NOW have pain, urgency or burning with Urination? Y N  
Ever passed blood in your urine? Y N

## NEUROMUSCULAR

Ever had a convulsion? Y N  
Ever had swollen, red or stiff joints? Y N  
Have paralysis or deformity? Y N

## ENDOCRINE

Any Thyroid problems? Y N  
Ever been told you are diabetic? Y N  
Has your weight varied over 10 pounds in the last year? Y N

## FAMILY HISTORY

List Disease and how it relates to you – Name: \_\_\_\_\_  
Cancer, Diabetes, Heart Disease, Stroke, Other Major History: \_\_\_\_\_

## SOCIAL HISTORY

Marital Status: \_\_\_\_\_ How Many Years? \_\_\_\_\_  
If Divorced, how long? \_\_\_\_\_

Is your marriage satisfactory? \_\_\_\_\_ Do you Drink? \_\_\_\_\_ How Much? \_\_\_\_\_  
Are you usually depressed lately? \_\_\_\_\_ Do you smoke? \_\_\_\_\_ How Much? \_\_\_\_\_  
Are you presently taking recreational drugs, marijuana, cocaine, etc? \_\_\_\_\_

## GYNECOLOGICAL & OBSTETRICAL HISTORY

Date of Last Pap? \_\_\_\_\_

Date of last Menstrual Period? \_\_\_\_\_ Was it Normal? \_\_\_\_\_ Days Flow? \_\_\_\_\_  
Number of Days Between Periods? \_\_\_\_\_ At What age did you begin your Period? \_\_\_\_\_  
How many pads/tampons per day at the beginning of your Period? \_\_\_\_\_ & at the End? \_\_\_\_\_

What type of Birth Control are you now using? (Please Circle ) None IUD Diaphragm Tubal ligation  
Vasectomy Pill (which one?) \_\_\_\_\_ or Other Method: \_\_\_\_\_

(Circle Y=Yes N=No for the following questions)

Are your periods irregular?	Y	N	Have you ever had a Pelvic Infection?	Y	N
Pain with or prior to Periods?	Y	N	Have you passed the "Change of Life"?	Y	N
Clots with Periods?	Y	N	If the above is Yes:		
Any bleeding between Periods?	Y	N	Have you had any bleeding?	Y	N
Any bleeding during or after sex?	Y	N	Any "Hot Flashes"	Y	N
Any pain with sex?	Y	N	Do you take hormones?	Y	N
Medication for pain with periods?	Y	N	Have you noticed any lumps or discharge		
Any Abnormal vaginal discharge?	Y	N	From breasts or nipples?	Y	N
Ever had a Venereal Disease?	Y	N	Do you lose urine when you cough or		
Ever had German Measles?	Y	N	Sneeze?	Y	N

## PREGNANCIES

How many Pregnancies? \_\_\_\_\_ How many Living Children? \_\_\_\_\_  
Age at First Pregnancy? \_\_\_\_\_

How many Miscarriages or Abortions? \_\_\_\_\_ Any Premature Babies? \_\_\_\_\_

List in order all your Pregnancies or use separate sheet if necessary:

Date      Sex      Weight      Any Complications      List- Cesarean Sections, Breech, Etc.

## DRUGS RECENTLY TAKEN

Pharmacy Name, address & phone – Attach additional sheet - \_\_\_\_\_

## ALLERGIES & SENSITIVITIES

Allergies & Sensitivities: \_\_\_\_\_

MAIL FORM TO: Suburban Women's Health Specialists, LTD., 2350 Royal Blvd., #600, Elgin IL 60123  
OR FAX TO: 847.622.3998 At least 72 hrs prior to your scheduled appointment.

**SUBURBAN WOMEN'S HEALTH SPECIALISTS, LTD.**

**847-931-4747**

2350 Royal Blvd., Suite 600, Elgin, IL 60123

Brad L. Epstein, M.D., F.A.C.O.G.

Christopher S. Michael, M.D., F.A.C.O.G.

Kathy M. Boerner, CNM

**INSURANCE VERIFICATION**

Our office requires this form **72 hours prior to your visit**. Send us this completed form along with a copy of your CURRENT insurance card (Back & Front). Please fax this information or stop in to our office in Elgin. Thank you for your cooperation in managing your insurance stipulations. (You will also need to present your insurance card at your visits.)

**OUR INSURANCE OFFICE FAX: #847.622.3998**

**NAME OF INSURANCE COMPANY:** \_\_\_\_\_ **TYPE:** \_\_\_\_\_ **REFERRAL?** \_\_\_\_\_  
Primary Insurance Name HMO/PPO/POS/EPO/IPA Yes or No

**CO-PAY? \$** \_\_\_\_\_ **DEDUCTIBLE: \$** \_\_\_\_\_ **HOSPITAL SPECIFIED BY INS?** \_\_\_\_\_

**Mailing Address for Billing your Insurance Company:** \_\_\_\_\_  
 \_\_\_\_\_

**Phone # for Verification of Ins:** \_\_\_\_\_  
**Phone # for Approval of Services:** \_\_\_\_\_  
(If you have a secondary insurance company, please send us that information as well.)

**Patients Primary Care Provider:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**PCP's Fax #:** \_\_\_\_\_

**PATIENT INFORMATION**

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DOB:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Employer Name:** \_\_\_\_\_  
**Phones:** (H) \_\_\_\_\_  
 (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

**INSURANCE POLICY OWNER INFORMATION**

**Guarantor's Name:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_ **SS#:** \_\_\_\_\_  
**Employed by:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**Relation to Patient: Spouse, Parent, Self, Other**  
(Please circle)

*Do not repeat information if Patient & Policy owner are the same.*

**Appointment Date/Office:** \_\_\_\_\_ **Elgin** (Circle Office) **Algonquin**  
2350 Royal Blvd 2971 W Algonquin Rd

**Reason for your appointment:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*OFFICE USE ONLY:*  
Procedure/Service Approved: \_\_\_\_\_ Date of Approval: \_\_\_\_\_  
Completed by: \_\_\_\_\_

Name of Ins. Rep: \_\_\_\_\_ Representing: \_\_\_\_\_  
Policy Limitations: \_\_\_\_\_

Which HUB does this patient belong to? \_\_\_\_\_ Labs are sent to: \_\_\_\_\_

**APPROVAL #** \_\_\_\_\_