17 Case Street
Norwich, CT 06360
860-886-2461

OB-GYN SERVICES, P.C.

PAST HISTORY FORM - Please Circle All That Apply

330 Washington St., Suite 340
Norwich, CT 06360
860-887-4198

Patient Name: ______________________________ Date of Birth: ______________

Current Date: ____________ Pharmacy: ____________________ Primary Language: ______________

ALLERGIES

List medications you are allergic to and the reaction (ie: hives, vomiting, difficulty breathing, etc.): ______________

____

MEDICATIONS

List the medications and supplements that you take - please include the dose and how often you take it:

____

____

____

____

____

____

____

LAST MENSTRUAL PERIOD

List the first day of your last period: ______________________

CURRENT CONTRACEPTION

Condoms	Mirena	Nuvaring	Tubal Ligation (Tubes Tied)
Depo Provera (Shots)	Nexplanon (Arm Implant)	Oral Contraceptives (Pills)	Vasectomy
Implanon (Arm Impant)	None/Menopause/Hysterectomy	Paragard IUD	Other__________

PAST MEDICAL HISTORY

None	Carotid Stenosis	End Stage Renal Disease	Lyme Disease
Allergic Rhinitis (Allergies)	Cataracts	Fibromyalgia	Memory Impairment
Anemia	Chronic Venous Stasis	Gastric / Peptic Ulcer (Stomach)	Migraine
Aneurysm, Aortic	Other:	GERD (Reflux)	Osteoporosis
Angina	CHF (Congestive Heart Failure)	GI Bleed (Vomiting Blood or Rectal Bleeding)	Ovarian Cyst
Anxiety	Chronic Pain __________ location	Glaucoma	PE (Pulmonary Embolism)
Arrhythmia	Cirrhosis (Liver)	Hepatitis	Polyps (Type______________)
Arthritis	COPD (Chronic Obstructive Pulmonary Disease)	High Colesterol	PVD (Peripheral Vascular Disease)
Asthma	CVA, TIA, Stroke	HIV / AIDS	Seizure (Epilepsy)
Atrial Fibrillation	Decubitus / Pressure Ulcer	Hypertension	Sleep Apnea
CAD (Heart Disease)	Depression	Insomnia	Thyroid Disease
CAD with MI (Heart Attack)	Diverticulosis / Diverticulitis	Kidney Stones	Uterine Fibroids
Cancer __________ type	DVT (Deep Venous Thrombosis)	Kidney Disease / Renal Insufficiency	Other: ______________

PAST SURGICAL HISTORY

None	Cardiac Defibrillator AICD	Hysterectomy (Uterus)	Tonsillectomy
Angioplasty	Cardiac Pacemaker	IVC Filter (Inferior Vena Cava)	Transplant (Type __________)
Aortic Aneurysm Repair	Cardiac Stents	Lumpectomy (Breast Lump)	Tubal Ligation (Tubes Tied)
Appendectomy (Appendix)	Cataract Surgery	Mastectomy (Breast Removal)	Valve Replacement
AV Fistula	CEA (Carotid Endarterectomy)	Orthopedic Surgery	Other: ______________
Bariatric Surgery (Gastric Bypass)	Cesarean Section	Replacement, Hip	
Bowel Resection	Cholecystectomy (Gallbladder)	Replacement, Knee	
Cardiac Bypass CABG (Heart)	Hernia Repair	Spinal Surgery	

Please Turn Over & Complete Second Page

OBSTETRIC HISTORY (PREGNANCIES)

List all deliveries:

Month / Year	Vaginal / Cesarean	Weight / Weeks	Locaton	Complications

List any miscarriages, terminations, ectopic (tubal) pregnancies, or molar pregnancies:

GYNECOLOGIC HISTORY

Abnormal Pap Smear/LEEP/Cryotherapy
Cervical Cancer
Ovarian Cancer
Uterine Cancer
Vaginal / Vulvar Cancer
Breast Cancer
Sexually Transmitted Infection
Menopause
Hormone Replacement Therapy
Painful Periods
Hysterectomy

Endometriosis
Heavy Periods
Irregular Periods
Polycystic Ovary Syndrome
Infertility
Osteopenia / Osteoporosis
Fibroids
Lichen Sclerosis
Vaginal Dryness
Urinary Incontinence
Myomectomy

Overactive Bladder
Abnonnal Mammogram/Breast Lump/Cyst
Ovarian Cysts
DES Exposure
Misshapen Uterus/Double Cervix or Vagina
Bartholin Cyst / Abscess
Genital Herpes
Gardasil Vaccine (all three shots? yes / no)
BRCA Gene Mutation
HNPCC/Lynch Gene Mutation
Endometrial Ablation

Other: ______________________________

SOCIAL HISTORY

Smoking : Never | Current Everyday (Packs Per Day ________) | Current Some Days | Former (Year Quit__________) | Other ______________ | Unkown

Alcohol Use: Never | Less than 10 Drinks / Week | More than 10 Drinks / Week | Alcoholic | Other ______________

Substance Use: Never | Cocaine | Heroin | Prescription Drugs | Other ______________
Former Use (what / when ______________________________)

Sexual Preference: Men | Women | Both

Marital Status: Married (name ______________________) | Divorced | Single | Widowed | Separated | Significant Other (name______________________________)

Occupation: ______________________________

Domestic Violence / Abuse: Never | Former | Current

FAMILY HISTORY (Please specify family member ie mother, father, sister, brother, etc)

None
Unknown
Aneurysm, Aortic
Asthma
CAD (heart disease)
CAD/MI (hearl attack)
Cancer (type ______________)
CVA/TIA/Stroke

Diabetes
DVT (deep venous thrombosis)
GERD (reflux)
High Cholesterol
Hypertension (high blood pressure)
Kidney Stones
Mental Illness
Migraine

Ovarian Cyst
PE (pulmonary embolism)
Renal Insufflciency (kidney disease)
Seizure (Epilepsy)
Substance Abuse
Thyroid Disease
Uterine Fibroids
Osteoporosis

Other: ______________________________

OB/GYN-RELATED CANCER HISTORY (Please specify family member & age of diagnosis)

Breast Cancer
Colon Cancer
Ovarian Cancer
Uterine Cancer
Other: ______________________________

SCREENING TESTS (when performed and what doctor or facility)

Last Mammogram: ______________________________
Last PAP Smear: ______________________________
Last Colonoscopy: ______________________________
Last Bone Density/DEXA Scan: ______________________________

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MISSED APPOINTMENT POLICY

OB-GYN Services does not charge for missed appointments or late cancellations. However, we ask you to show consideration by notifying our office at least 24 hours in advance if you are unable to keep your appointment. This will allow our physicians to have the option to offer that appointment to another patient who needs to be seen.

If you miss three appointments without notifying our office, you will be dismissed from the practice. If you are dismissed from our practice, you will not be able to schedule any further appointments.

I have read and understand OB-GYN's missed appointment policy.

____
Patient or Patient's Representative Signature

____
Date

OB-GYN SERVICES, P.C.
FINANCIAL POLICY

Thank you for choosing OB GYN SERVICES for your healthcare needs. Please understand that payment of your bill is considered your responsibility. The following is a statement of our Financial policy which we require you to read and to sign prior to any treatment. To achieve the practice goals of providing the finest medical care at the lowest possible cost, we need your assistance in the following:

PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, DISCOVER, AMERICAN EXPRESS, AND MASTERCARD.

If you have insurance coverage, we will file the claim for you. Payment for treatment is your responsibility. All copays and deductibles are due at the time of service and must be paid prior to any treatment or surgery.

If an insurance problem occurs, you may be asked to assist us in contacting your insurance carrier. please be aware that some of the services provided may be non-covered and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

We will check the status of your insurance benefits when we schedule any procedure. If your deductible has not been met, we will require payment of that amount and any additional co-insurance or co-pay responsibility.

Return checks may be subject to any bank fees and a collection fee of $25.00 per check.

If you have any questions about financial arrangements, please feel free to talk with our billing office at 860-886 -2461. We will make every effort to clarify any concerns regarding your financial responsibility.

Thank you for your assistance in this matter.

I HAVE READ THE ABOVE FINANCIAL POLICY AND AGREE TO ABIDE BY ITS TERMS.

_______________________________________   ____________________

Signature of Patient or Responsible Party   Date

_______________________________________   ____________________

Print Patient Name   Date of Birth

OB-GYN SERVICES, P.C.

PRACTICE LIMITED TO OBSTETRICS & GYNECOLOGY

17 CASE ST.
NORWICH, CONNECTICUT 06360
TELEPHONE 860-886-2461

330 WASHINGTON STREET, SUITE 340
NORWICH, CONNECTICUT 06360
TELEPHONE 860-887-4198

David A. Kalla, M.D.
Stephen T. Briggs, M.D.
Suzelle A. Hendsch, M.D.
Melissa J. Welch, M.D.
Matthew W. Brown, M.D.
Julie Z. Belcher, M.D.

Kristin Scarlata, A.P.R.N.
Melissa Bergfeld, A.P.R.N.
Tyann Nordness, L.N.M.
Maureen Davis, L.N.M.
Carol Rinzler, L.N.M.
Kathleen Gauthier, L.N.M.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

OB-GYN Services, P.C. has my consent to use and disclose my protected health information with their office to carry out treatment, payment and all other healthcare operations.

I have received a copy of OB-GYN Services, P.C.'s Notice of Privacy of Practice. I understand that OB-GYN Services, P.C. reserves the right to revise it's Notice of Privacy Practices at anytime. A revised Notice of Privacy may be obtained by forwarding a written request to OB-GYN Services, P.C., Attn: Privacy Officer at 17 Case Street, Norwich, CT 06360.

OB-GYN Services, P.C. has my consent to call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the proactive in carrying out all healthcare operation, such as appointment reminders, messages for me to call regarding insurance items, my clinical care, including laboratory results, amount others

OB-GYN Services, P.C. has my consent to mail to my home or designated location any items that assist the practice in carrying out all healthcare operations, such appointment reminders and patient statements as long as they are marked Personal and Confidential.

OB-GYN Services, P.C. has my consent to e-mail to my home or other designated location any items that may assist the practice in carrying out all healthcare operation. I have the right to request that OB-GYN Services, P.C. restrict how it uses or discloses any of my personal healthcare information for their healthcare operations. However, the practice is not required to agree to requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to let OB-GYN Services, P.C. use and disclosure of my personal health information to carry out all healthcare operation. I understand that I may revoke my consent in writing except to the extent that the practice has already make disclosures in reliance upon my prior consent. If I do not sign this consent, OB-GYN Services, P.C. may decline to provide me with treatment.

______________________________ Signature of Patient or Legal Guardian

______________________________ Relationship to Patient

______________________________ Patient's Name

______________________________ Date

______________________________ OB-GYN Services, P.C. Represented

Patient Information

Date: ______________ Name: ____

Address: ____

No. & Street Town State & Zip Code

Home Phone: ________________________________ Work Phone: ______________________________________

Date of Birth: ____________________ SS#: ______________________________ Marital Status: M S D Sep

Employer: ____

Occupation: ____

Insurance Coverage Information

Primary Insurance Co.: ____

Group #: ____________________________________ ID#: ____

Policy Holder: ________________________________ Relationship: ___________________________________

Employer: ________________________________ Address: _______________________________________

Secondary Insurance Co.: ____

Group #: ____________________________________ ID#: ____

Policy Holder: ________________________________ Relationship: ___________________________________

Employer: ________________________________ Address: _______________________________________

This office does not accept all insurances. Some insurances (such as Medicare) do not cover routine annual gyn exams. It is the patient's responsibility to be aware of their company's policies and procedures. Appropriate payment or co-pay is due when service is rendered.

<u>RELEASE OF BENEFITS:</u>

I hereby authorize my insurance benefits be paid directly to OB-GYN Services, P.C. and acknowledge that I am financially responsible for any unpaid balance. I also authorize this office to release any information required by my insurance company.

Patient Signature: ____ Date: ________________________