



Obstetrics & Gynecology, P.C.
Competent, compassionate health care for women.

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WELCOME TO OUR OFFICE

Appointment Date: _____
 Name _____
 Birthdate _____ Marital Status _____ Maiden Name _____
 Address _____ City _____ State _____ ZIP _____
 Phone # _____ Cell? Yes No Work or Message Phone _____
 If a child, parent's or guardian's name _____
 Race: White Black Asian Indian/Alaskan Pacific Island Other/Multi
 Ethnicity: Hispanic non-Hispanic
 Patient's Employer _____ Occupation _____
 Social Security # _____

Please provide receptionist with all your insurance cards and Driver's License

Do you have Medical Insurance: Yes or No If no, how do you intend to pay? _____
 Insurance Co. Name _____ Insured's DOB _____
 Insured's Employer _____ Insured's Social Security # _____
 Person financially responsible for this account? _____
 Address _____ Phone: _____

What is the name of your family physician? _____

In case of an emergency, please contact _____ Phone _____

Who may we thank referring you? _____ What will you be seen for today? _____

Does your lab work need to go to a specific lab? Yes No

Circle one: Quest Lab Corp McLaren Port Huron Lake Huron Med Center Other

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 _____

Patient Questionnaire Page 2

PRESENT MEDICATIONS (Include birth control pills and over the counter medications, example: Supplements)

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?
During the past month, have you often been bothered by feeling down, depressed, or hopeless?			
During the past month, have you often been bothered by little interest or pleasure in doing things?			

FAMILY HISTORY List known conditions and diseases of any blood relative in your immediate family. Also include intellectual disability and birth defects.

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP