Jill Gibson, M.D.
Obstetrics & Gynecology

NEW PATIENT REGISTRATION

Last Name	MI	First Name	Date of Birth

Social Security Number	Marital Status	Ethnicity/Language

Address	City	State	Zip Code

Home Phone	Cell Phone	Email

Work Phone	Occupation	Employer

Emergency Contact Name	Phone	Relationship

Circle Provider To Be Seen:
Dr. Gibson Dr. Landry Dr. Rinaldo Allison Falcone, NP Elizabeth McLain, NP

Insurance Information

Insurance Company Name	Group Number	Insurance Holder's SSN
	ID Number	Insurance Holder's DOB
Insurance Holder's Name	Relationship to Patient Self__ Spouse__ Child__ Other__	Work Status Employed ____ Unemployed ____ Retired ____ Student ____
	Gender (circle one) Male Female	

Assignment of Insurance Benefits

I hereby authorize direct payment of medical/surgical benefits to Jill Gibson, MD LLC for services rendered. I also understand that I am financially responsible for any payment and/or balance not covered by my insurance.

I hereby authorize any information about me to be released to my health insurance carrier and its agents, including any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Jill Gibson, MD LLC to release any medical records that may be necessary for medical care or the processing of applications for financial benefits.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices which explains how my Protected Health Information will be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

Please Print: Patient Name (or Legal Guardian)	Relationship to Patient
Signature	Date

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OB/GYN HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. All information given will be kept strictly confidential.

Main reason for today's visit:_____
Other concerns:_____

PAST MEDICAL HISTORY

Please check all that apply

- ☐ Anemia or Blood Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast Cancer
- ☐ Ovarian Cancer
- ☐ Uterine Cancer
- ☐ Cervical Cancer
- ☐ Other Cancer _____
- ☐ Diabetes
- ☐ Endometriosis
- ☐ HIV
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Liver Disease
- ☐ Kidney or bladder problems
- ☐ Lung Disorder
- ☐ Mental Illness
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Reflux
- ☐ Seizures / Convulsions
- ☐ Stomach/Bowel Problems
- ☐ Transfusions
- ☐ Other

Hormonal Concerns

- ☐ Fatigue
- ☐ Hot Flashes
- ☐ Vaginal Dryness
- ☐ Weight Gain
- ☐ Night Sweats
- ☐ Low Libido/Decreased Sex Drive
- ☐ Mental Fogginess
- ☐ Mood Disturbances
- ☐ Other

GYNECOLOGIC HISTORY

Age at first menstrual period: _____
Date of last menstrual period: _____
Birth Control _____
Menopausal Yes No

Date of last Dexascan _____

Last Pap Smear Date _____
☐ Abnormal

Last Mammogram Date _____ ☐ Abnormal

History of STDs Yes No
Type/Date:

History of Sexual Abuse Yes No

Other

PAST SURGICAL HISTORY

Surgery	Reason	Year	Hospital
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

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FAMILY HISTORY

Please specify mother, father, sibling, or other:

- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ Hypertension _____
- ☐ Stroke _____
- ☐ Other _____

SOCIAL HISTORY

Tobacco Yes / No ☐ Cigarettes __ / day ☐ Other ___/day	**Recreational Drugs** **Yes / No** **If yes, list type:**	**Alcohol** Yes / No If yes, how often (drinks per week)?	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widow	**Sexual Preference** ☐ Heterosexual ☐ LGBTQ
Occupation	**Exercise** ☐ None ☐ < 3 times/week ☐ > 3 times/week		**Caffeine** Yes / No Drinks per day ___ ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks	

OBSTETRIC HISTORY

Number of Pregnancies:_____

Date	Gestational Age	SVD/C-Section/Miscarriage/Ectopic	M/F	Weight	Complications

PREFERRED PHARMACY

Pharmacy Name	Pharmacy Address	Pharmacy Phone

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MEDICATIONS

Please list all medications you are taking, including both prescription and non-prescription.

Drug Name	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		

List others here:

_____

_____

ALLERGIES

List anything you are allergic to and how each affects you (include medications, foods, etc.)

Drug / Object	Reaction
1.	
2.	
3.	
4.	
5.	

Please add any additional information you would like your doctor to know below:

_____

_____

_____

_____

_____

_____

How did you hear about our practice? _____

_____ _____

Signature Date

Print name:_____ Relationship to Patient:

☐ Self ☐ Parent ☐ Guardian ☐ Caregiver