KURT R. FINBERG, MD

OBSTETRICS GYNECOLOGY

PATIENT INFORMATION SHEET

PATIENT'S ACCOUNT #	WHO REFERRED YOU?	EMAIL
NAME (LAST, FIRST, M.I.)		PHONE #
ADDRESS	CITY STATE	ZIP CODE
SOCIAL SECURITY NO.	DATE OF BIRTH	MARITAL STATUS SINGLE____ MARRIED ____ DIVORCED____ WIDOWED____
YOUR EMPLOYER		WORK TELEPHONE ( ) - x
EMPLOYER'S ADDRESS	CITY STATE	ZIP CODE
SIGNIFICANT OTHER'S NAME	SIGNIFICANT OTHER'S EMPLOYER	
EMERGENCY CONTACT	RELATIONSHIP	TELEPHONE

PRIMARY INSURANCE INFORMATION PLEASE PROVIDE INSURANCE CARD	
NAME OF INSURANCE:	
WHO IS THE INSURED? (CIRCLE ONE:) SELF SPOUSE PARENT	
THEIR NAME:	THEIR DATE OF BIRTH:
MEMBER ID #	GROUP #

SECONDARY INSURANCE INFORMATION PLEASE PROVIDE INSURANCE CARD	
NAME OF INSURANCE:	
WHO IS THE INSURED? (CIRCLE ONE:) SELF SPOUSE PARENT	
THEIR NAME:	THEIR DATE OF BIRTH:
MEMBER ID #	GROUP #

I hereby authorize all insurance bebefits to be paid directly to KURT R. FINBERG, M.D. I understand that I am responsible for charges as designated by my insurance companies (e.g. deductibles, co-payments, etc.) I am also resposible for all charges not covered by insurance, and for any finance fees incurred on unpaid balances. I authorize to KURT R. FINBERG, MD. to relase any information to my insurance companies when requested by them.

DATE	SIGNED (Insured or Authorized)

OB/GYN QUESTIONNAIRE

Name____________________________________ Date_____________________

1. When did you have your last pap smear? ____

2A. What was the first day of your last period?__________________ Was the period normal?__________
When was your period before that?________________.

B. Are your periods regular?_________________ If not, what are the limits of irregularity?_________
____.

C. Are you on estrogens or birth control?_________________ Which one?_______________________
How long?________________________ Any problems?_____________________________________.

D. Have you had any abnormal bleeding since your last period?___________________ If so, when?
____.

E. Are your periods heavy?____________ If yes how many pads / tampons do you use during an average period?____.

F. Age you began your menstruation:____.

G. Do you have pain with periods?____.

H. Do you have bleeding between periods?____.

3. Do you have a discharge?___________ After intercourse?_________________________________
Does it itch, burn or have an odor?____.

4. Date of all pregnancies:

	Year	Term or Miscarriage	Birth Weight		Year	Term or Miscarriage	Birth Weight
1.	_______	_____________	__________	4.	_________	____________	_________
2.	_______	_____________	__________	5.	_________	____________	_________
3.	_______	_____________	__________	6.	_________	____________	_________

5. Length of longest labor______________________ Shortest_______________________________

6. Have you had any of the following with your pregnancies:

___________ 1. Cesarean Section
___________ 2. Serious Bleeding in pregnancy
____________ 3. High Blood Pressure
____________ 4. Kidney Trouble
____________ 5. Toxic Poisoning/Pre-Eclampsia

7. List all Operations you have had and give dates of operations:
____

____

____.

CONTINUED ON BACK

8. Check illnesses listed below which you have had:

______________ German Measles
______________ Rheumatic Fever
______________ Heart Trouble
_______________ Kidney Trouble
_______________ Sugar Diabetes
_______________ Other Serious Illness

9. What medications are you on?____
____.

10. Have you ever had a blood transfusion?____.

11. Who, in your family or relatives, has ever had:

________________ Diabetes
________________ Cancer
________________ Twins
_______________ Heart Disease
________________ Tuberculosis
________________ Other Serious Illness

12 What is your usual weight?____.

13 (If Pregnant) What did you weigh before becoming pregnant?______________________________.

14 Do you smoke?_________________ How many packs a day?______________________________.

15 Are you allergic to any medications?____________ Which ones:____________________________
____.

16 What is your reason for being here today?____
____
____.

I understand, and agree, that after my insurance has been billed that I will be responsible for any remaining balance and deductibles.

___________________________________(Signature) _________________________(Date)

I give permission to release medical records to my current insurance company, only at their request, in order to pay on a medical claim.

___________________________________(Signature) _________________________(Date)

I understand that Dr. Finberg's medical office is HIPPA compliant ad they cannot share my health information due to the privacy and confidentiality law.

___________________________________(Signature) _________________________(Date)

KURT R. FINBERG, M.D. , INC.
OBSTETRICS & GYNECOLOGY
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OBSTETRICAL CARE

Most insurance covers 80% of OB Care and
20% is the patient's responsibility plus any deductible that hasn't been met.
We will collect monthly co-pays or payments towards 20% of OB Care.
It is your responsibility to contact your insurance and confirm what your deductible and what your plan covers for OB Care.

Vaginal Delivery	Cesarean Delivery
Charge $2900.00	Charge $3100.00

Initial OB visit with ultrasound is a separate charge from OB Care and will be billed to your insurance; you may be responsible for 20% of this initial visit. OB Care includes one monthly visit (unless otherwise advised) until the end of pregnancy. There will also be a charge for First Trimester Nuchal Screening/Ultrasound (optional and usually recommended for high-risk patients) and one extended ultrasound about 18 to 22 weeks gestation, to evaluate normal fetal anatomy. There may also be a charge for RhoGAM injections (Negative blood type) for those who require it, your insurance may not cover all these charges, and therefore it will be your responsibility.

Any other office visits that are not for OB care (i.e., for a vaginal infection, bronchitis, etc.) are not included in global billing and will be billed to your insurance separately. If you are requesting any additional ultrasounds for non-medical indication (i.e., sex determination) and Cord Blood collection for stem cell preservation, these are to be paid out of pocket and not charged to insurance.

You are required to contact your insurance company to see if you have a deductible and if it has been met. Deductibles are separate from your 20% responsibility.

__________________________________ ________________

I have read all the above and understand. **Date**