

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 <small>SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___</small>	
YOUR EMPLOYER		WORK TELEPHONE <small>() - X</small>	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE
SIGNIFICANT OTHER'S NAME	SIGNIFICANT OTHER'S EMPLOYER		
EMERGENCY CONTACT	RELATIONSHIP	TELEPHONE	

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

SECONDARY INSURANCE INFORMATION	
<small>PLEASE PROVIDE INSURANCE CARD</small>	
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 benefits 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 responsible for all charges not covered by insurance, and for any finance fees incurred on unpaid balances. I authorize to KURT R. FINBERG, MD. to release 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:

8. Check illnesses listed below which you have had:

_____ German Measles	_____ Kidney Trouble
_____ Rheumatic Fever	_____ Sugar Diabetes
_____ Heart Trouble	_____ 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	_____ Heart Disease
_____ Cancer	_____ Tuberculosis
_____ Twins	_____ 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 and they cannot share my health information due to the privacy and confidentiality law.

_____ (Signature) _____ (Date)