KURT R. FINBERG, MD
OBSTETRICS GYNECOLOGY
PATIENT INFORMATION SHEET

PATIENT'S ACCOUNT #	**WHO REFERRED YOU?**	**YOUR 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**		
SPOUSE'S NAME	**SPOUSE'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	_____ 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 ad they cannot share my health information due to the privacy and confidentiality law.

_____(Signature) _____(Date)