

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 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)

KURT R. FINBERG, M.D. , INC.
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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