

Mobile Reproductive Endocrinology
and Infertility Center, P.C.
Shannon M. Gilmore, M.D.

CHART # _____
DATE _____

*PATIENT INFORMATION (PLEASE PRINT):

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	AGE
		MARITAL STATUS: M S W D		
SOCIAL SECURITY NUMBER				

MAILING ADDRESS	CITY	STATE	ZIP CODE
-----------------	------	-------	----------

BILLING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE
---	------	-------	----------

HOME PHONE	CELL PHONE	WORK PHONE
------------	------------	------------

DRIVER'S LICENSE NUMBER	STATE	CREDIT CARD #	EXP. DATE	V-CODE
-------------------------	-------	---------------	-----------	--------

EMPLOYER NAME AND ADDRESS

*RESPONSIBLE PARTY (CIRCLE ONE): SELF SPOUSE PARENT OTHER: _____

**IF A PARENT IS THE RESPONSIBLE PARTY PLEASE FILL IN THE FOLLOWING INFORMATION:

NAME	SOCIAL SECURTITY NUMBER	DATE OF BIRTH
EMPLOYER NAME AND ADDRESS		WORK PHONE

*SPOUSE INFORMATION:

NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH
EMPLOYER NAME AND ADDRESS		WORK PHONE

*EMERGENCY CONTACT (PERSON NOT LIVING WITH YOU):

FULL NAME	RELATIONSHIP	CONTACT NUMBER
-----------	--------------	----------------

*PHARMACY:

NAME/LOCATION	PHONE NUMBER
---------------	--------------

*REFERRED BY: _____

Mobile Reproductive Endocrinology & Infertility

6332 Piccadilly Square Dr. Mobile, AL 36609

Patient Name: _____

Date: _____ Chart #: _____

NEW PATIENT QUESTIONNAIRE

Why have you come to the office today?

Is this a new problem? _____

Please describe your problem. (where, when, duration, severity) _____

Who is your Primary Physician? _____

GYNECOLOGIC HISTORY

First day of your most recent period? _____ How long did it last? _____

At what age did your periods begin? _____ How many days are in between periods? _____

Any recent changes in your periods? (length or flow) _____

Have you ever had sex? _____ Are you currently sexually active? _____ How many partners? (lifetime) _____

Sexual partners are _____ men _____ women _____ both.

What method of contraception are you **currently** using? _____

What methods of contraception have you used in the past and for how long? _____

When was your last Pap Smear? _____ What was the result? _____

Have you ever had an abnormal Pap Smear? _____

When was your last Mammogram? _____ Where was it performed? _____

What was the result of your last Mammogram? _____

When was your last Bone Density? _____ Where was it Performed? _____

What was the result of your last Bone Density? _____

When was your last Colonoscopy? _____

SOCIAL & PERSONAL HISTORY

Have you ever smoked? _____ How many years? _____ How many packs per day? _____

Do you drink alcohol? _____ How many drinks per week? _____ Type of drinks: _____

Do you use illegal drugs or misuse prescription drugs? _____ What drugs do you use? _____

Do you have safe driving habits? _____

Do you have health hazards at home or work? _____

Have you been abused or hurt by anyone? _____

Do you have an Advance Directive or Living Will? _____

Are you an organ donor? _____

Are you _____ Married _____ Single _____ Divorced _____ Widowed? (check one)

Current job: _____

Have you traveled outside the U.S.? _____ Where & when? _____

WHAT SYMPTOM ARE YOU HAVING TODAY?	Y or N	WHAT SYMPTOM ARE YOU HAVING TODAY?	Y or N
BREASTS		GENITOURINARY	
Pain		Blood or Pain with urination	
Lump		Urgency or Frequency	
Nipple discharge		Incomplete urination	
CARDIOVASCULAR		Involuntary urine loss	
Chest Pain or Pressure		Abnormal vaginal bleeding/Irregular Periods	
Breathing difficulty		Painful periods	
Swelling of legs		PMS	
Rapid or Irregular heartbeat		Pain during sex	
CONSTITUTIONAL		Abnormal vaginal discharge	
Weight loss or gain		Vaginal dryness or irritation	
Fever		HEMATOLOGIC/LYMPHATIC	
Fatigue		Frequent bruises	
Change in height		Cuts do not stop bleeding	
EARS, EYES, NOSE, THROAT		Enlarged Lymph nodes	
Vision Changes		MUSCULOSKELETAL	
Glasses/Contacts		Weakness	
Hearing Problems		Joint pain	
Ringing or Pain		NEUROLOGIC	
Sinus Problems		Dizziness or Numbness	
Sore Throat or Mouth		Seizures or Headaches	
Dental Problems		Trouble walking	
ENDOCRINE		Memory problems	
Hair loss		PSYCHIATRIC	
Heat/Cold intolerance		Depression	
Abnormal thirst		Anxiety	
Hot flashes/Night sweats		Mood Swings	
Insomnia		RESPIRATORY	
GASTROINTESTINAL		Painful breathing/Shortness of breath	
Diarrhea or Constipation		Wheezing or Cough	
Bloody Stool		Spitting up blood	
Nausea/Vomiting		SKIN	
Involuntary loss of gas or stool		Rash, Moles or Sores	
Abdominal Pain/Pelvic Pain		Dry skin	
ALLERGIES Please list the name of drug or substance you are allergic to & its reaction.			

Form completed by: _____ Patient _____ Nurse _____ Physician _____ Other _____

Patient Signature: _____ Print Name _____

Physician Signature: _____ Date _____

Mobile Reproductive Endocrinology & Infertility

6332 Piccadilly Square Dr. Mobile, AL 36609

Patient Name: _____

Date: _____ Chart #: _____

OB HISTORY

Total # Pregnancies _____ Total # Live Births _____ Total # Miscarriages _____ Total # Premature _____

	Birth Date	SEX	WEIGHT AT BIRTH	TYPE OF DELIVERY	WEEKS PREGNANT
1.					
2.					
3.					
4.					

Any Complications? _____

Gestational Diabetes? _____ Hypertension/High Blood Pressure _____ Preeclampsia/Toxemia _____

SURGICAL & HOSPITALIZATION HISTORY

TYPE/REASON	DATE	PHYSICIAN	HOSPITAL

FAMILY HISTORY

ILLNESS	Y or N	WHO & AGE OF ONSET	PHYSICIAN'S NOTES
Alzheimer's			
Blood Clots			
Breast Cancer			
Colon Cancer			
Diabetes			
Heart Disease			
Hepatitis			
High Blood Pressure			
High Cholesterol			
HIV/AIDS			
Mental Illness			
Ovarian Cancer			
Osteoporosis			
Stroke			
Tuberculosis			
Uterine Cancer			
Other:			

Is your mother living? _____ Current Age _____ Is your father living? _____ Current Age _____

Number of Siblings alive: _____ Number of deceased Siblings: _____

Mobile Reproductive Endocrinology & Infertility

6332 Piccadilly Square Dr. Mobile, AL 36609

Patient Name: _____

Date: _____ Chart #: _____

CURRENT MEDICATIONS & VITAMINS

Please list **ALL** substances you use: medications, vitamins, creams, gels, patches or injectable

NAME OF DRUG/VITAMIN	DOSAGE & DIRECTIONS	PHYSICIAN

PERSONAL CURRENT & PAST ILLNESSES

Please review list and mark which illnesses **YOU** have had or currently have:

YOUR ILLNESS	Y or N	PHYSICIANS NOTES	YOUR ILLNESS	Y or N	PHYSICIANS NOTES
Anemia			Gallbladder		
Anxiety			Glaucoma		
Arthritis			Headaches		
Asthma			Heart Attack/Disease		
Autoimmune Disorders			Hepatitis		
Bleeding Disorders			High Blood Pressure		
Blood Clots			HIV/AIDS		
Blood Transfusion			Infertility		
Bowel Problems			Kidney Inf/Stones		
Broken Bones			Osteoporosis		
Cancer			Pneumonia		
Cataracts			Rheumatic Fever		
Chicken Pox			Seizures		
Depression			STD's		
DES Exposure			Stomach Issues		
Diabetes			Stroke		
Eating Disorders			Thyroid Issues		
Endometriosis			Tuberculosis		
Fibroids			Other		

Mobile Reproductive Endocrinology and Infertility Center, P.C.

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

We will be happy to complete and file your insurance claims. In most cases, we will accept what your insurance company pays. Payment for the portion of your bill not covered by insurance is your obligation and is due at the time services are rendered. We accept cash, check, and all major credit or debit cards. We will also assist you with a Care Credit account.

Unfortunately, some of the procedures utilized in your treatment are not covered by commercial insurance carriers. Charges not covered by insurance will be your responsibility and must be paid at the time of service. Co-payments are always due on the day of service.

We will gladly discuss you proposed treatment and answer any questions related to your insurance.

YOU MUST REALIZE:

1. Your insurance coverage is based on a contract between you, or your employer, and the insurance company. We are not a party to that contract.
2. Verification of insurance coverage is not a guarantee of payment. Benefits are subject to the terms and limitations of your plan such as:
 - a. Pre-existing conditions
 - b. Non-covered services
 - c. Waiting periods
 - d. Utilization limits
3. All insurance balances will be your responsibility after sixty (60) days.
4. Most insurance policies pay only a limited amount, or a percentage such as 50% or 80%, of what they declare to be "Usual, Customary, and Reasonable" (U.C.R.) for a given geographic region.
5. Our specialized practice often deals with medical problems that have failed to respond successfully to other treatments. Providing you the care you seek, may in some instances require extra effort, time, tests, and procedures. The fees for these services may not always be within the range your insurance company has declared to be the usual, customary and reasonable fees for ordinary care as compared with the special care you might have needed from this office.
6. Our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility.
7. When you schedule an appointment with us, we commit a period of time to adequately serve you. If you are unable to keep the appointment, we are unable to use that time. Appointments that are not cancelled 24 hours prior to the scheduled visit will incur a charge of \$60.00.
8. In the event of default, you agree to pay the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of the note.
9. Accounts delinquent past 30 days will be charged at the rate of 1.5% interest per month with a \$3.00 minimum monthly charge. When your account reaches 90 days old, your account will be turned over to collections.
10. There will be a \$30.00 administrative fee per year for the following requests: FMLA, Physicals or Wellness paperwork, Prior Authorizations for prescriptions, Patient Assistance forms, or prescriptions requested by the patient outside of an appointment.

If you have any questions or any uncertainty regarding these policies, PLEASE do not hesitate to ask us. We are here to help you.

Please review this policy with any other party who may be responsible for payment of services rendered in this office.

I authorize MOBILE REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY CENTER, P.C. to render any medical treatment deemed necessary by the physician(s) to myself or to the patient named herein, and to release any medical information necessary to process health claims and request payment to the party that accepts assignment.

Patient (or responsible party) Signature

Date

Spouse (or responsible party) Signature

Date

Acknowledgement of Receipt of Notice of Privacy Practices

Mobile Reproductive Endocrinology and Infertility Center, P.C. reserves the right to modify the privacy practices outlined in notice.

I have received a copy of the Notice of Privacy Practices for Mobile reproductive Endocrinology and Infertility Center, P.C.

Name of Patient

Date

Signature of Patient/Responsible Party