

MILFORD OB-GYN PHYSICIANS, P.C.
309 SEASIDE AVENUE – SUITE 203-204 • MILFORD, CT 06460 – (203) 878-5913
TIM SHARPE, M.D., F.A.C.O.G

PLEASE FILL OUT AND RETURN TO OUR OFFICE AT THE TIME OF YOUR VISIT
If your scheduled visit must be cancelled, we would appreciate 24 hours notice
THIS IS PART OF YOUR MEDICAL RECORD AND IS KEPT CONFIDENTIAL.

Last Name _____ SS No. _____
First _____ Mid. Init. _____
Maiden _____ Age _____ DOB _____
Address _____
City _____ State _____ Zip _____
H Tel: _____ W Tel: _____
Occupation _____ Religion _____
Place of Employment _____
Address _____
City _____ State _____ Zip _____

Husband/Significant Other's Name(Circle One)

First _____ SS No. _____
Age _____ DOB _____
Address _____
City _____ State _____ Zip _____
H Tel: _____ W Tel: _____
Place of Employment _____
Address _____
City _____ State _____ Zip _____

INSURANCE INFORMATION:

PRIMARY: _____ ID# _____ GRP# _____
Subscribers name: _____ SS# _____ DOB _____
SECONDARY: _____ ID# _____ GRP# _____
Subscribers name: _____ SS# _____ DOB _____

Referred by: _____

Gynecology: Date of last PAP smear _____ Date of Last Menstrual Period _____ Age of First Menstrual Period _____

Do you have problems with your periods or abnormal vaginal bleeding? No Yes _____

Do you have any: Vaginal discharge: No Yes _____ Bleeding or pain with intercourse: No Yes _____

Social History: Single Married Separated Divorced Widowed **Husband:** Age _____ Weight _____ Health _____

Birth Control Method Used: The Pill Condoms Diaphragm Sponge Sterilization Rhythm Withdrawal IUD

Do you use alcohol? No Yes _____ **Drugs** No Yes _____ **Cigarettes** No Yes _____

Past Medical History: Please check (✓) if you have had these, with year, if known:

Measles _____ Heart Disease _____ Mumps _____ Chicken Pox _____

Epilepsy, Seizures _____ German Measles _____ Blood Disorders _____ Blood Transfusion _____

Venereal Diseases _____ High Blood Pressure _____ Diabetes _____ Phlebitis _____

Thyroid Disease _____ Kidney Disease, Kidney Stones _____ Other (specify) _____

Are you ALLERGIC to any medications? (please list) _____

Do you take any medications regularly? _____ Do you have any current medical concerns? _____

PAST SURGICAL HISTORY: HAVE YOU EVER HAD SURGERY? (Please fill in dates if applicable)

Appendix _____ Gallbladder _____ Tonsils _____ Tumors _____ Spine _____
Breast _____ Ovary _____ Tubes _____ Uterus (hysterectomy) _____ Vaginal Repair _____
D+C _____ Cervix _____ Other _____

Birth Date	Sex	Infant Weight	No. of Months Pregnant	Type of Delivery (Normal, Breech, Forceps, Cesarean)	Length Labor	Anesthesia	Weight Gain	Remarks (Hospital Problems, Rhogam, etc.)

Have you had any Miscarriages? No Yes _____

If you are currently pregnant, list any discomforts you are having: _____

Family History? Do you have family members with a history of the following:

Cancer _____ Epilepsy _____ Diabetes _____ Blood Disease _____
Heart Disease _____ Muscular or Nervous Disorders _____ High Blood Pressure _____
Twins _____ Birth Defects _____ Other _____

Are your parents alive? No Yes _____ Do you have brother(s) No Yes _____ How many _____

Do you have sister(s) No Yes _____ How many _____

Assignment of Insurance Payments

Signature required – Please read

As per your contract and ours with your insurance company, co-pays are due at the time of visit and are not billable. There will be no exceptions, so please be prepared to pay at time of check in.

I hereby authorize payment directly to MILFORD OB/GYN PHYSICIANS, P.C. I understand that I am fully responsible for charges not covered by my Insurance Company. In the event that this office needs to obtain legal assistance in collection of any unpaid balance, I/we agree to pay costs and attorney fees as allowable by law.

If your Insurance plan requires a **written referral** from your primary Doctor, one must be obtained before the appointment or you will be rescheduled.

SIGNATURE: _____

MEDICARE PATIENTS ONLY

Signature required – Please read

I request that payment under the Medicare/Metrahealth insurance program be made directly to MILFORD OB/GYN PHYSICIANS, P.C. I understand that I may be held responsible for a portion of these bills after Medicare has paid the provider, or for charges Medicare does not cover.

SIGNATURE: _____