Mary A. Durbin & Becky A. Lang **HEALTH HISTORY FORM** **Height: _____**

Name:_____ Birthday:_____ Age:_____ SS#_____

Address:_____ City:_____ State:_____ Zip:_____

What name would you like to be called by?_____

Phone:_____ Cell:_____ Work:_____

Email:_____

Emergency Contact:_____ Phone:_____ Relation:_____

Family Doctor:_____ Phone:_____

Pharmacy:_____ Location:_____

HEALTH INSURANCE INFORMATION

PRIMARY

Insurance Company:_____

Subscriber DOB:_____

Relationship to Subscriber:_____

SECONDARY

Insurance Company:_____

Subscriber DOB:_____

Relationship to Subscriber:_____

CURRENT CONDITIONS

☐ AIDS	☐ Chemical dependency	☐ Herpes	☐ Multiple Sclerosis	☐ Ulcers
☐ Arthritis	☐ Diabetes	☐ High cholesterol	☐ Mumps	☐ Venereal Disease
☐ Asthma	☐ Emphysema	☐ HIV positive	☐ Pacemaker	☐ Other_____
☐ Bleeding disorder	☐ Epilepsy	☐ Hypertension	☐ Pneumonia	_____
☐ Breast lump	☐ Glaucoma	☐ Kidney disease	☐ Stroke	_____
☐ Cancer	☐ Heart disease	☐ Liver disease	☐ Thyroid Problem	_____
☐ Cataracts	☐ Hepatitis	☐ Migraine headaches	☐ Tuberculosis	

SURGICAL HISTORY/MAJOR ILLNESS

Year	Type of Illness/Surgery	Hospital	Doctor	Complications
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FAMILY HISTORY

Relation (Mother, Father, etc.)	**Type of disease** (ex: diabetes, cancer, high blood pressure, etc)	**Status** (ex: deceased, controlled with medication, etc)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Marital Status:_____

Type of Employment:_____

Use seat belt? ☐Yes ☐ No

Exercise Regularly? ☐**Yes** ☐ No

Smoking ☐No ☐Yes Packs/day_____ #Years_____

Alcohol ☐No ☐Yes ☐ Occasionally/Socially

Drinks per day:_____ Drinks per week:_____

Illicit Drugs ☐No ☐Yes Type:_____

Frequency:_____

MEDICATIONS – PRESCRIPTION/OVER THE COUNTER

Name of Drug	Dose/Frequency	Reason

DRUG ALLERGIES

Known drug allergies? ☐ No ☐ Yes List allergy:_____

Known latex allergy? ☐ No ☐ Yes

Known food allergy? ☐ No ☐ Yes List allergy:_____

GYNOCOLOGICAL HISTORY

Last Period:_____ Cycle Length:_____days Days bleeding:_____

Cycle: ☐ Regular ☐ Irregular **Flow**: Heavy ☐ Moderate ☐ Light ☐ Cramps: ☐ Yes ☐ No severity_____

Birth Control: ☐ Yes ☐ No _____

Menopause: ☐ Yes ☐ No Age:_____ Hormone Replacement Therapy:_____

History of vaginal infections (ex: HSV, gonorrhea, chlamydia, HPV) ☐ Yes ☐ No _____

Last Pap:_____ Last Mammogram:_____

Abnormal Pap: ☐ Yes ☐ No Last Dexa Scan:_____

Treatment on cervix: ☐ Yes ☐ No If so, what:_____

OBSTETRICAL HISTORY

	Total pregnancies:			**Total living children:**		**Total miscarriage/termination:**	
Name	**Gender**	**C-Section Vaginal**	**Birth Weight**	**Year**	**Doctor/Midwife**	**Hospital**	**Complications**

Constitutional			**Gastrointestinal**			**Respiratory**			**Endocrine**			**Dermatological**		
Fatigue	Y	N	Abdominal pain	Y	N	Wheezing	Y	N	Appetite change	Y	N	Rash/itch	Y	N
Weight changes	Y	N	Naseau/vomiting	Y	N	Coughing	Y	N	Excessive thirst	Y	N	Change in mole/lesion	Y	N
Fever/Chills	Y	N	Indegestion/heartburn	Y	N	Shortness of breath	Y	N	Fatigue/slugishness	Y	N	Breast lump/discharge	Y	N
Difficulty sleeping	Y	N	Bowel/change in stool	Y	N	Asthma	Y	N	Too hot/cold	Y	N			
Night Sweats	Y	N	Diarrhea/constipation	Y	N									
Ears, Nose, Throat, Mouth			**Neurological**			**Genitourinary**			**Allergies**			**Musculosketal**		
Ear infection	Y	N	Tremors	Y	N	Painful urination	Y	N	Hay Fever	Y	N	Joint pain	Y	N
Hearing problem	Y	N	Dizziness	Y	N	Frequency of urination	Y	N	Drug Allergies	Y	N	Neck pain	Y	N
Sinus	Y	N	Numbness/tingling	Y	N	Loss of urine	Y	N	Food Allergies	Y	N	Back pain	Y	N
Sore throat	Y	N				Urinary urgency	Y	N						
Cardiovascular			**Hematologic**			**Psychiatric**			**Eyes**			**Other:**_____		
Chest pain	Y	N	Swollen glands	Y	N	Moody	Y	N	Blurred vision	Y	N	_____		
Varicose Veins	Y	N	Bleeding problems	Y	N	Depressed	Y	N	Pain	Y	N	_____		
Shortness of breath	Y	N				Considered suicide	Y	N	Glaucoma	Y	N	_____		
High blood pressure	Y	N				Anxiety	Y	N						

I authorize Mary Durbin/Becky Lang to release information to insurance carriers regarding my medical care, and I hereby assign Mary Durbin/Becky Lang all payment for services rendered to me or my dependents. I understand that I am responsible for any amount not covered by the insurance.

Patient/Gaurdian:_____ Date:_____

Reviewed: Date/Dr _____ _____ _____ _____ _____

Notice of Privacy Practice – HIPAA

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information.
You may refuse to sign this acknowledgement if you wish.
I acknowledge that I have received a copy or have been notified of my right to a copy of this office's Notice of Privacy Practices.

Signature:_____ Date:_____

Patient Responsibility for HMO Referral

Any HMO/managed care insurance policy that requires a referral to be seen by a specialist is the responsibility of the patient. Your insurance will deny paying a claim if this authorization is not in place. Any charge unpaid by your insurance is your responsibility.
***Wellness exams do not require a referral**.*

Signature:_____ Date:_____

Medicaid – State Funded Health Care

This office does ***not*** participate with any Medicaid programs. If you have a life event that requires you to apply for Medicaid please be aware that you may be asked to transfer care to a physician who participates with your insurance. We cannot bill any Medicaid program for services as we are a non-participating physician.
This includes Medicaid as a secondary insurance as well.

Signature:_____ Date:_____

Durbin & Lang OB-GYN Financial Policy

We do everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of billing statements we send to you. The following is a summary of our payment policy.

INSURANCE

We bill participating insurance companies as a courtesy to you. You are expected to pay any charges that are not covered by your insurance including co-pays, deductibles and co-insurances.

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

Payment is required at the time of service unless other arrangements have been made in advance. This includes all applicable co-pays, co-insurances and deductibles for participating insurances. We can accept cash, personal checks, VISA, MasterCard and Discover. Payments can be made by calling the office with your credit card information. Any returned check will have a $25.00 service charge added to your account to cover services fees imposed by the bank.

OUTSTANDING BALANCES

A patient with an outstanding balance is encouraged to call the office and set up a payment arrangement. We realize that financial difficulty is a reality. An interest free payment plan is available upon request. Payment arrangements require monthly payments on your account. If circumstances arise and your account has been delinquent for more than 90 days, your account will be sent to a collection agency. A charge of an additional 30% will be added to your account to cover the cost of the collection agencies fees. Any patient that is sent to the collection agency will also be discharged from the practice and no longer able to have medical care with the doctor.

REFUNDS

Patient/guarantor credits in amounts less than $20.00 will be retained on the account to be credited towards future balances unless a request for a refund has been received. Amounts greater than $20.00 will automatically be refunded to the patient/guarantor.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, other patients could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to you appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

If you need assistance or have questions please call the office between 8:00am and 4:00pm Monday through Thursday at (989)891-9900.

I have read and understand the financial policy of Dr. Durbin and Dr. Lang.
I agree to assign insurance benefits to Dr. Durbin and Dr. Lang whenever necessary.
I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, that I will be responsible for the fees charged by the collection agency for the cost of collections.

_____ _____

Signature of insured or authorized representative Date