Mary A. Durbin & Becky A. Lang
HEALTH HISTORY FORM

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 _____ _____ _____ _____ _____

Consent to Treat

This consent provides us with your permission to perform reasonable and necessary medical exams, testing and treatment. By signing below, you are indicating that you intend that this consent is continuing after a specific diagnosis has been made and a treatment has been recommended.

Patient Signature:_____ Date:_____

Parent Signature (if minor):_____

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. 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:_____

Participation with State Funded Medicaid Insurances

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 insurance 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. 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 for Dr. Durbin and Dr. Lang.
I agree to assign insurance benefits to Dr. Durbin and Dr. Lang for services rendered.

_____ _____

Signature of insured or authorized representative Date