

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

SECONDARY

Insurance Company: _____

Insurance Company: _____

Subscriber DOB: _____

Subscriber DOB: _____

Relationship to Subscriber: _____

Relationship to Subscriber: _____

CURRENT CONDITIONS

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

SURGICAL HISTORY/MAJOR ILLNESS

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

FAMILY HISTORY

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

SOCIAL HISTORY

Marital Status: _____ Smoking No Yes Packs/day _____ #Years _____

Type of Employment: _____ Alcohol No Yes Occasionally/Socially

Use seat belt? Yes No Drinks per day: _____ Drinks per week: _____

Exercise Regularly? Yes No 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

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

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

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/Guardian: _____ Date: _____

Reviewed: Date/Dr _____

Consent to Treatment

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.

Signature of Patient of Representative

Date

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 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 rights to have a copy of this office's Notice of Privacy Policy.

Signature of Patient of Representative

Date

Participation with State Funded Medicaid Programs

This office does NOT participate with any state Medicaid plan. If you have a life event that requires you to apply of Medicaid please be aware that you may be asked to transfer care to a physician who participates with your insurance. This includes Medicaid as a secondary insurance.

We can not bill any Medicaid plans as we are a non-participating physician.

Signature of Patient of Representative

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