

White Rose Ob/Gyn Associates  
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Welcome to the White Rose Ob/Gyn Associates

Welcome to the White Rose Ob/Gyn Associates. Whether you are here as a gynecological or obstetrical patient, we strive to provide you with exceptional care. Our practice has been providing quality care for over 25 years and are proud to be delivering second generations. We are a family centered practice promoting natural childbirth.

Our practice participates with many insurances. If you are uncertain whether we participate with your insurance, please contact the office or call your insurance company directly.

If you have a copay with your insurance, please be aware that it will be collected at the time of your visit prior to seeing the doctor. You will be given a receipt upon checkout. Failure to pay your copay at the time of your visit will result in a \$12.00 billing service charge being added to your account. If you are here for a preventive visit, but have medical concerns addressed and/or treated that are not considered "preventive," your insurance may subject you to an additional copay. This would be determined based on the contract that you have with your insurance company.

If you are in need of emergency care, you must go to Memorial Hospital unless your insurance specifies otherwise.

If you do not have insurance, full payment will be expected at the time of service unless prior arrangements have been made.

Patients with a credit balance can request a refund at any time.

Thank you for choosing White Rose Ob/Gyn Associates. We look forward to providing you with quality healthcare.

If you have any questions, please contact the office at the above number.

PATIENT NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

**SPOUSE/SIGNIFICANT OTHER**

NAME: \_\_\_\_\_ SS#: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

NAME OF PERSON RESPONSIBLE FOR PAYMENT: \_\_\_\_\_

**INSURANCE COMPANY**

NAME: \_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_

PHARMACY PHONE NUMBER: \_\_\_\_\_

MEDICAID RECIPIENT NUMBER: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER. ALL COPAYS ARE EXPECTED BEFORE BEING SEEN. PLEASE SEE THE RECEPTIONIST TO MAKE PAYMENT.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO WHITE ROSE OB/GYN ASSOCIATES FOR ANY SERVICES FURNISHED ME BY THAT PARTY WHO ACCEPTS ASSIGNMENT/PHYSICIAN. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION, OR ITS INTERMEDIARIES OR CARRIERS, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM/OTHER INSURANCE COMPANY CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT. (SECTION 1128B OF THE SOCIAL SECURITY ACT AND 31 U.S.C. 3801-3812 PROVIDES PENALTIES FOR WITHHOLDING THIS INFORMATION)

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**NEW PATIENT HISTORY**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_ AGE \_\_\_\_\_

CURRENT PROBLEM OR REASON FOR VISIT: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

PAST FEMALE PROBLEMS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

PAST SURGERIES: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

DATE: \_\_\_\_\_

ANESTHESIA: \_\_\_\_\_

HOSPITAL: \_\_\_\_\_

LIST ANY PROBLEMS YOU HAVE HAD WITH SURGERY OR ANESTHESIA:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST ANY OTHER HOSPITALIZATIONS AND THE REASON FOR HOSPITALIZATION:

\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

LIST ANY ALLERGIES TO MEDICATIONS OF FOODS: \_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY**

DO YOU SMOKE: \_\_\_\_\_ HOW MANY YEARS: \_\_\_\_\_

HOW MANY PACKS: \_\_\_\_\_

DID YOU QUIT: \_\_\_\_\_ IF YES, WHEN: \_\_\_\_\_

DO YOU DRINK ALCOHOL: \_\_\_\_\_ HOW MUCH: \_\_\_\_\_

**MEDICAL HISTORY**

LIST ANY MEDICAL PROBLEMS THAT YOU HAVE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CURRENT BIRTH CONTROL METHOD: \_\_\_\_\_

AGE PERIOD STARTED: \_\_\_\_\_ AGE PERIOD STOPPED: \_\_\_\_\_

HOW MANY DAYS DO YOUR PERIODS LAST: \_\_\_\_\_

DESCRIBE YOUR PERIOD, LIGHT, HEAVY OR FLOODING: \_\_\_\_\_

WHAT WAS THE FIRST DAY OF YOUR LAST PERIOD: \_\_\_\_\_

DO YOU TAKE MEDICATION FOR RELIEF OF CRAMPING DURING YOUR PERIOD:

\_\_\_\_\_

DO YOU HAVE ANY FEMALE/PELVIC PAIN: \_\_\_\_\_

IF YES, EXPLAIN: \_\_\_\_\_

\_\_\_\_\_

DO YOU GET REGULAR PAP SMEARS: \_\_\_\_\_

WHEN AND WHERE WAS YOUR LAST PAP SMEAR: \_\_\_\_\_

DO YOU HAVE PAIN WITH INTERCOURSE: \_\_\_\_\_

DO YOU HAVE ANY ABNORMAL DISCHARGE: \_\_\_\_\_

DO YOU HAVE FREQUENT FEMALE INFECTIONS: \_\_\_\_\_

HOW HAVE THEY BEEN TREATED: \_\_\_\_\_

\_\_\_\_\_

WERE YOU EVER TREATED FOR A PELVIC INFECTION: \_\_\_\_\_

WERE YOU EVER TREATED FOR ENDOMETRIOSIS: \_\_\_\_\_

DID YOU HAVE TROUBLE GETTING PREGNANT: \_\_\_\_\_

HAVE YOU EVER MISSED A LOT OF PERIODS: \_\_\_\_\_

DO YOU HAVE ABNORMAL HAIR GROWTH: \_\_\_\_\_

DID YOU EVER HAVE BREAST PAIN: \_\_\_\_\_

DID YOU EVER HAVE BREAST DISCHARGE: \_\_\_\_\_

DID YOU EVER HAVE BREAST CYST: \_\_\_\_\_

DO YOU HAVE A HISTORY (YOURSELF OR FAMILY) OF BREAST OR OVARIAN

CANCER: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

HAVE YOU HAD A MAMMOGRAM: \_\_\_\_\_

IF YES, WHERE AND WHEN: \_\_\_\_\_

**PREGNANCY HISTORY**

NUMBER OF TIMES PREGNANT: \_\_\_\_\_

DATES OF DELIVERIES: \_\_\_\_\_

NUMBER OF MISCARRIAGES: \_\_\_\_\_

NUMBER OF PREMATURE BIRTHS: \_\_\_\_\_

HOW MANY LIVING CHILDREN DO YOU HAVE: \_\_\_\_\_

**COMPLICATIONS OF CHILDBIRTH (PLEASE CHECK ANY THAT APPLY)**

DIABETES \_\_\_ HYPERTENSION \_\_\_ INFECTIONS \_\_\_ BLEEDING \_\_\_

MEDICAL PROBLEMS \_\_\_ C-SECTION \_\_\_ STILLBORN \_\_\_ FETAL DISTRESS \_\_\_

FORCEPS \_\_\_ VACUUM \_\_\_

ANY CHILDREN WITH COMPLICATIONS: \_\_\_\_\_

**MY HEALTH IS:**

GOOD: \_\_\_ FAIR: \_\_\_ POOR: \_\_\_

IF YOU HAVE CHECKED POOR OR HAVE ANY HEALTH PROBLEMS OR ISSUES YOU WOULD LIKE TO DISCUSS, PLEASE LIST IT HERE:

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