*Elizabeth Pernal, M.D., P.A.*
GYNECOLOGY
813-A Eastern Shore Drive
Salisbury, MD 21804
Office: (410) 860-5151
Fax: (410) 860-2026

# PATIENT REGISTRATION AND HEALTH QUESTIONAIRE

**Date of Visit:** _______________

**Who may we thank for referring you?** ____________________________________

**PATIENT INFORMATION**

| Patient Name (Last, First, Middle) | | Date of Birth (MM/DD/YYYY) | SSN | |
|---|---|---|---|---|
| Address | City | | State | Zip Code |
| Home Phone | Cell Phone | | Other | |
| Occupation/Employer | | | | |
| Primary Care Physician | | | | |
| Parent/Guardian *(If Under 18)* | | | | |
| Emergency Contact (Name) | | Relationship | | |
| Home Phone | Cell Phone | | Other | |

**INSURANCE INFORMATION**

| **Primary Insurance Company** | **Secondary Insurance Company** |
|---|---|
| Company | Company |
| Subscriber Name | Subscriber name |
| Relationship | Relationship |
| Subscriber DOB | Subscriber DOB |

# PATIENT HISTORY

## Reason For Visit:

______________________________________________________________________________

______________________________________________________________________________

## Known Drug Allergies:

______________________________________________________________________________

______________________________________________________________________________

## Past Medical and Family History

- *Please mark* **(X)** *for all items that apply.*
- *Under 'Explanation', provide basic details and indicate whether the condition exists on the maternal or paternal side and which family member is affected. (ex. Paternal Grandmother)*

| | SELF | FAMILY | EXPLANATION |
|---|---|---|---|
| 1. Weight Gain/Loss | ☐ | ☐ | ________________ |
| 2. Headaches/Migraines | ☐ | ☐ | ________________ |
| 3. Urinary Incontinence | ☐ | ☐ | ________________ |
| 4. Urinary Infections | ☐ | ☐ | ________________ |
| 5. Blood Transfusions | ☐ | ☐ | ________________ |
| 6. Anxiety | ☐ | ☐ | ________________ |
| 7. Depression | ☐ | ☐ | ________________ |
| 8. Anemia | ☐ | ☐ | ________________ |
| 9. Diabetes | ☐ | ☐ | ________________ |
| 10. Cancer | ☐ | ☐ | ________________ |
| 11. High Blood Pressure | ☐ | ☐ | ________________ |
| 12. Heart Disease | ☐ | ☐ | ________________ |
| 13. Respiratory/Lung Disease | ☐ | ☐ | ________________ |
| 14. Thyroid Disease | ☐ | ☐ | ________________ |
| 15. Skin Disease | ☐ | ☐ | ________________ |
| 16. Epilepsy/Neurologic Disorder | ☐ | ☐ | ________________ |
| 17. Endocrine Disorder | ☐ | ☐ | ________________ |
| 18. Hearing Loss | ☐ | ☐ | ________________ |
| 29. Infectious Diseases | ☐ | ☐ | ________________ |
| 20. Gastrointestinal Problems | ☐ | ☐ | ________________ |
| 21. Infertility | ☐ | ☐ | ________________ |


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## Hospital Admissions

- *List those operations and serious illnesses which required hospitalization (excluding pregnancy).*

| YEAR | REASON FOR ADMISSION | YEAR | REASON FOR ADMISSION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Medications

- *List all medications you are currently taking to include over-the-counter drugs.*
- *Include dosage and frequency.*

| DRUG | FREQUENCY | DOSAGE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Obstetrical History

LIST THE NUMBER OF: PREGNANCIES ____, PREMATURE BIRTHS ____,
MISCARRIAGES ____, ABORTIONS ____

LIST THE NUMBER OF ALL LIVING CHILDREN ____ *(Please complete the table below for each living child)*

| BORN (Month/Year) | WEEKS PREGNANT | GENDER (M/F) | TYPE OF DELIVERY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |


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## Gynecological History

- *Please mark* **(X)** *for any problems you have experienced in the past.*

☐ Abnormal Pap Smear ☐ Irregular Periods ☐ Nipple Discharge

☐ Bleeding Between Periods ☐ Painful Intercourse ☐ Breast Lump

☐ Bleeding with Intercourse ☐ Urinary Problems ☐ Vaginal Discharge

☐ Extreme Menstrual Pain ☐ Hot Flashes ☐ Vaginal Infections

**INFECTIONS**

☐ Yeast ☐ Trichomonas ☐ Bacterial Vaginosis ☐ Chlamydia ☐ Gonorrhea ☐ Herpes

AGE AT FIRST PERIOD _______ DATE OF L.M.P. ______________

NUMBER OF DAYS BETWEEN PERIODS ______ DURATION OF BLEEDING ________________

ARE YOU SEXUALLY ACTIVE? _________ MORE THAN ONE PARTNER? _________

DATE OF YOUR LAST PAP SMEAR ___________ RESULTS ___________________________

DATE OF YOUR LAST MAMMOGRAM ____________ RESULTS __________________________

| BIRTH CONTROL METHODS | YEARS USED | PROBLEM / REASON / DISCONTINUED |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Social History

| | YES | NO | |
|---|---|---|---|
| **Tobacco Use** ...................................... | ☐ | ☐ | If Yes, how much per day? ___________ |
| **Alcohol Use** ....................................... | ☐ | ☐ | If Yes, how much per week? ___________ |
| **Coffee/Caffeine Use** ........................... | ☐ | ☐ | If Yes, how many cups per day? __________ |
| **Street Drug Use** ................................. | ☐ | ☐ | If Yes, what kind? ___________ |


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Patient Name: ______________________________________ DOB: _________________

## Assignment of Insurance Benefits

I hereby assign all medical and/or surgical insurance benefits to Elizabeth Pernal MD PA.
I hereby authorize direct payment of all medical and/or surgical insurance benefits to Elizabeth Pernal MD PA for services rendered by Elizabeth Pernal MD in person or under her supervision. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. A copy of this assignment may be sent to my insurance company. If I receive an insurance payment directly, I agree to make full payment immediately to Elizabeth Pernal MD PA.

## Release of Medical Information

I consent to the use and/or disclosure of my protected health information by Elizabeth Pernal MD PA for the purposes of obtaining payment. I will provide a current copy of my health insurance identification card, policy number and demographic information to Elizabeth Pernal MD PA upon request. I also authorize Elizabeth Pernal MD PA to act as my representative and on my behalf to secure all authorization necessary from my insurance company regarding medical care or procedures performed by Elizabeth Pernal MD PA including, if necessary, any appeal of a denial of benefit.

## Financially Responsible

I understand that I am financially responsible for payment of all my medical bills from Elizabeth Pernal MD PA.

**I certify that I have read and agree to the information on this page.**

Signature____________________________________________Date___________________

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# Financial Policies

Patient Name: ____________________________________ DOB: ________________

We expect any amount you currently owe Elizabeth Pernal MD PA to be paid in full prior to the time of service. You are responsible for payment of all of your medical bills from Elizabeth Pernal MD PA.

**If You Do Not Have Insurance:** We expect payment in full prior to the time of service. If you cannot make complete payment, we require that you make payment arrangements with the billing department prior to receiving service and make a mutually agreed upon partial payment prior to service being rendered.

**If You Have Insurance:** We will bill your insurance company for you as long as we have the correct insurance information. We will prepare insurance claims and accept assignment of your benefits from your primary and secondary insurance. You are expected to pay your co-pay, any applicable deductibles, and any estimated amounts owed prior to the time of service. It is your responsibility to know your insurance benefits, assure payment of insurance benefits to us and negotiate with your insurance company over disputed claims. We require you as a patient to be responsible for any balance your insurance does not pay.

**Forms of Payment:** We accept cash, checks and major credit cards or debit cards, including Visa, MasterCard and Discover. There will be a $30.00 charge on all returned checks.

**Delinquent Accounts:** If we deem your account to be delinquent we may add reasonable late charges to your account; furthermore, we may turn your account over to a professional agency specializing in debt collection. If your account is turned over either to a collection agency or to an attorney, you agree to pay any and all fees owed to Elizabeth Pernal MD PA plus any additional reasonable collection fees charged by the collection agency plus any and all legal fees of collection, with or without suit, including attorney fees and court costs.

**Statements:** You will receive periodic statements for any outstanding balance until your bill is paid in full, whether you have insurance or not.

**I certify that I have read and agree to the Financial Policies of Elizabeth Pernal MD PA. I understand that I am responsible for payment of all of my medical bills from Elizabeth Pernal, MD, PA.**

Signature____________________________________________Date___________________