

# NEW PATIENT INFORMATION

SPARKS&FAVOR, P.C.

Name		Social Security Number	
Address			
		City	State
		Zip Code	
Home Phone Number	Cell Phone Number	Work Phone Number	
Birthday        /        / month        day        year	Marital Status M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/>		
Place of Employment		Occupation	
Husband's Name	Date of Birth	Occupation	
Place of Employment		Work Number	
Referring Doctor/Primary Physician			

## INSURANCE INFORMATION

Insurance Company	Contract/Policy Number
Group Number and Name of Employer	
Name of Policy Holder	
Address	
Insurance Company	Contract/Policy Number
Group Number and Name of Employer	
Name of Policy Holder	
Address	

## In Case of Emergency Please Notify:

Name	Relationship
Address	
City	
State	
Zip Code	
Home Phone Number	Work Phone Number

## MEDICARE ASSIGNMENT

Statement to permit payment of medical benefits to physicians.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request the payment of authorized benefits be made on my behalf. I assign benefits payable for physicians service or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

## ALL OTHER INSURANCE

I hereby authorize Sparks & Favor, P.C. to release any information acquired in my examination or treatment to any insurer, government agency providing benefits, or to anyone for charges.

I hereby assign and authorize payment directly to Sparks & Favor, P.C. of all benefits payable under the terms of any insurance policy listed above. I realize the insurance, and/or liability claims may not pay all of the bill. I agree to pay the difference or the entire bill if necessary. I also agree to pay costs of collection, including Attorney's fee and waive my exemption under the constitution and laws of the State of Alabama.

Signed \_\_\_\_\_ Date \_\_\_\_\_



**Menstrual History:**

Date Last Period Started: \_\_\_\_\_ How many days do you bleed each cycle? \_\_\_\_\_

Are you having any problems with your menstrual cycle?     No     Yes

Describe your menses:     Regular     Irregular     Heavy     Painful     Clots

How long is your menstrual cycle? \_\_\_\_\_ days (1st day of one period to 1st day of next period)

**Contraception** (at the present time):     None     Hysterectomy     Tubal Ligation     Vasectomy  
 Birth Control Pill     Condoms     Diaphragm     IUD     Rhythm

**Have you noticed recent problems related to the following:**

General Health?     No problems     Yes –     Wt. Gain     Wt. Loss     Fever     Fatigue  
 Other: \_\_\_\_\_

Eyes?     No problems     Yes –     Vision Change     Glaucoma  
 Other: \_\_\_\_\_

Ear/Nose/Throat?     No problems     Yes –     Ulcers     Sinusitis     Ringing in Ears  
 Other: \_\_\_\_\_

Heart?     No problems     Yes –     Chest Pain     Shortness of Breath     Irregular Heart Beat  
 Other: \_\_\_\_\_

Lungs?     No problems     Yes –     Wheezing     Cough     Coughing Up Blood  
 Other: \_\_\_\_\_

Stomach/Colon?     No problems     Yes –     Diarrhea     Blood in Stool     Nausea     Constipation  
 Other: \_\_\_\_\_

Kidney/Bladder?     No problems     Yes –     Blood in Urine     Dysuria     Urgency     Frequency     Incontinence  
 Other: \_\_\_\_\_

Muscles/Bones/Joints?     No problems     Yes –     Muscle Weakness     Joint Pain     Muscle Pain  
 Other: \_\_\_\_\_

Nervous System?     No problems     Yes –     Fainting Spells     Seizures     Numbness     Memory Loss  
 Other: \_\_\_\_\_

State of Mind?     No problems     Yes –     Depression     Crying     Anxiety  
 Other: \_\_\_\_\_

Endocrine System?     No problems     Yes –     Diabetes     Thyroid Disorder     Heat/Cold Intolerance  
 Other: \_\_\_\_\_

Blood & Lymph Nodes?     No problems     Yes –     Easy Bruising     Free Bleeder     Enlarged Lymph Nodes     Transfusions  
 Other: \_\_\_\_\_

Skin?     No problems     Yes –     Rash     Ulcers     Moles (Enlarging/Changing)  
 Other: \_\_\_\_\_

Breasts?     No problems     Yes –     Pain in Breast     Nipple Discharge     Breast Nodule  
 Other: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE COMPLETE IF YOU ARE PREGNANT OR PLANNING A PREGNANCY.**

Please help us evaluate potential genetic risks for you pregnancy by answering the following questions. Please check the 'Yes' or 'No' answer. Please provide the details of any positive in the space at the bottom of this page.

Have you, the baby's father or anyone in either family ever had:

- Down's Syndrome \_\_\_\_\_  Yes  No
- Other Chromosome Abnormality \_\_\_\_\_  Yes  No
- Neural Tube Defect, such as Open Spine \_\_\_\_\_  Yes  No
- Any Other "Birth Defects" \_\_\_\_\_  Yes  No
- Cystic Fibrosis \_\_\_\_\_  Yes  No
- Muscular Dystrophy \_\_\_\_\_  Yes  No
- Sickle Cell Disease \_\_\_\_\_  Yes  No
- Hemophilia \_\_\_\_\_  Yes  No
- Mental Retardation \_\_\_\_\_  Yes  No
- Tay Sachs Disease \_\_\_\_\_  Yes  No
- Multiple Miscarriages \_\_\_\_\_  Yes  No
- Diabetes \_\_\_\_\_  Yes  No
- Thalassemia (Inherited Anemia) \_\_\_\_\_  Yes  No

<b>If you or your spouse is:</b>	<b>Have you been tested for:</b>	<b>Results:</b>
_____ Black	Sickle Cell <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____ Italian, Greek	B-Thalassemia <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____ Mediterranean	Tay Sachs <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____ Southeast Asian		
_____ Jewish		

Besides vitamins, have you taken any medication since your last period? \_\_\_\_\_

If yes, please list medication: \_\_\_\_\_

Have you ever used "recreational" drugs?  Yes  No

Have you ever had herpes, gonorrhea, or syphilis?  Yes  No

Chlamydia, genital warts, or any sexually transmitted disease?  Yes  No

Details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Your Name (Please Print)                      Date                      Your Signature