# Patient Information

(Please Print) Date _____

Patient: _____ Birthdate _____ Age _____
First Maiden Last

Address _____
Street City State Zip

Home Phone: _____ Social Sec. Number _____

EMPLOYMENT _____ How Long? _____

Employment Address: _____ Work No. _____

SPOUSE/PARENT _____ Soc Security # _____ D.O.B ____/____/____

Employment: _____ How Long? _____

Address: _____ Work No. _____

Relatives, Other Phone Numbers You Can Be Reached? _____

Who Referred You To Us? _____

INSURANCE:

Primary: _____ Contract Number _____
Name

Secondary: _____ Contract Number _____
Name

**WHO WILL BE RESPONSIBLE FOR YOUR BILL? _____

Address _____
Street City State Zip

DATE _____ SIGNATURE _____

Initial Office Visit is $ _____ CASH BASIS ONLY

Best phone number to reach you during the day _____

Pharmacy name and location _____

Cell Phone _____

2055 E. South Blvd.
Baptist Medical Tower #712
Montgomery, AL 36116

Stuart T. May, M.D.

Phone 288-1950

Name _____ Date of Birth _____

MENSTRUAL HISTORY:

Started at age _____ Length of cycle _____ (Days from start of one to start of next period)

Number of days period lasts _____ Date of last normal menstrual period _____

Periods regular: Yes No Pain or cramps: Yes Sometimes No

Do you ever bleed between periods? Yes No

Flow: Light Medium Heavy Excessive

Last Pap Smear _____ Result _____

What contraception (Birth Control) method are you using? _____

UNDERLINE THE REASON(s) YOU CAME TO SEE THE DOCTOR:

Pain Irregular Bleeding Possible Pregnancy Vaginal Discharge

Urinary Symptoms Pap Test Family Planning Infertility

Protruded Organs Routine Check-Up Other: _____

HISTORY (Do not write in this space) _____

GIVE THE FOLLOWING INFORMATION FOR THE LAST 3 TIMES YOU HAVE BEEN HOSPITALIZED, STARTING WITH THE MOST RECENT

(Do Not List Pregnancies)

| | HOSPITALIZATION (1) | HOSPITALIZATION (2) | HOSPITALIZATON (3) |
|---|---|---|---|
| Type of Operation or Illness | | | |
| Date Hospitalized | | | |
| Name of Hospital | | | |
| Doctor | | | |

OVER

**Check if any time in your life you have had any of the following:**

| | | |
|---|---|---|
| ( ) Infection of Female Organs | ( ) Frequent Headaches | ( ) High Blood Pressure |
| ( ) Vaginal Discharge/Itching | ( ) Migraine | ( ) Gallbladder Disease |
| ( ) Loss of urine/incontinence | ( ) Trouble with sinuses | ( ) Indigestion, Stomach probs. |
| ( ) Pain/Bleeding w/intercourse | ( ) Diarrhea/Constipation | ( ) Epilepsy |
| ( ) Hot Flashes/night sweats | ( ) Chronic Cough | ( ) Thyroid Disease |
| ( ) Hemorrhoids, itching | ( ) Shortness of Breath | ( ) Diabetes |
| ( ) Kidney or Bladder inf. | ( ) Asthma | ( ) Cancer |
| ( ) Gonorrhea/Syphilis | ( ) Chest Pain | ( ) Skin Disease |
| ( ) Painful/freq. urination | ( ) Pneumonia | ( ) Tuberculosis |
| ( ) Swelling of hands/feet | ( ) Heart Disease | ( ) German Measles/Mumps |
| ( ) Breast Tenderness | ( ) Heart Murmur | ( ) Chicken Pox |
| ( ) Discharge from breast | ( ) Trouble w/eyes or ears | ( ) Scarlet or Rheumatic fever |
| ( ) Lumps in breast | ( ) Anemia | ( ) Jaundice |
| ( ) Infertility | ( ) Fatigue / Fainting spells | ( ) Nausea or Vomiting |

**Are we your Primary Care Physician _____yes _____no (if we are listed with your insurance co. as your primary care physician we need your previous medical records.**
**Name of Family Dr./Internist/Specialist_____**
**What medications are you presently taking(list):_____**
**Allergies(list):_____**
**Last Tetanus_____ Last Cholosterol screening_____**

**Alcoholic Beverages: Never_____ Socially_____ Moderate_____ Daily_____**
**Cigarettes:_____ Pack(s) per day**
**Any History of substance abuse_____**

**Previous Pregnancies Information**
**How many times have you been pregnant?_____**
**Full Term Babies_____ Premature_____ Miscarriages_____**
**Stillborns_____ Number of Prev. C/Sections_____ Number of Vaginal Deliveries_____**
**Any complications(list)_____**

**Family History Information/list any member of your family who has ever had:**

**Heart Disease_____ Cancer_____ Kidney Disease_____**

**High Blood Pressure_____ Epilepsy_____ Stroke_____**

**Thyroid Disease_____ Liver Disease_____ Clotting Problems_____**

**Bleeding Disorder_____ Diabetes_____ Mental Illness_____**

**Birth Defects_____ Twins_____ Tuberculosis_____**

# ALABAMA GYNECOLOGY ASSOCIATES

Complete Primary Women's Care

Baptist Medical Tower
2055 East South Blvd., Suite 712
Montgomery, AL 36116
334-288-1950
1-800-430-1950

Stuart T. May, M.D.
*Board Certified OB/GYN*


## Consent for Treatment
## Assignment of Benefits/Financial Responsibility
## Release of Information
## Notice of Privacy Practices Acknowledgement

I consent for medical treatment by Dr. Stuart T. May.

I authorize Dr. May to apply for insurance benefits on my behalf for covered services rendered. I understand that I am responsible for copays, deductibles and co-insurances at the time services are rendered. I also understand I am responsible for any non-covered services. Patients also are responsible for any collection and legal fees in the event of default.

I authorize the release of any medical information necessary to process my insurance claim. I also certify that the information I have reported with regard to my insurance coverage is correct.

The Health Insurance Portability & Accountability Act of 1996 (**HIPAA**) is a federal program that requires that all medical records and health information used by us in any form are kept confidential. This Act, gives you, the patients, significant new rights to understand and control how your health information is used. HIPAA provides penalties for misuse of personal health information. If you wish to review these procedures further please ask for more information and we will provide this for you.

**You have the following rights with respect to your health information:**

1. The right to access, inspect, and copy your health information.
2. The right to request an amendment to your health record.
3. The right to receive an accounting of certain disclosures of your health information
4. The right to receive confidential communications.
5. The right to request restrictions on disclosures concerning your health information.

**** I hereby consent that medical information and test results can be discussed with the following person or persons_____.

(Spouse, parent, etc., / leave blank if you want us to discuss with only you.)

****I hereby consent that appt reminders can be left on answering machine or with a family member. _____(Initial)

_____ _____

Date Signature(must be over 18).