OPTIMUM WOMEN'S CARE

Nancy A. Magsino, M.D., FACOG

PATIENT INFORMATION

Patient Name		Marital Status (circle one) Single Married Divorced Separated Wid-		
Social Security Number	Driver's License Number	Driver's License State	Birthdate	Age
Email Address			May we leave results via email? Yes No	
Home Phone	Cell Phone		May we leave results on voice mail? Yes No	
Street Address				
City	State		Zip Code	
Employer	Work Phone		Occupation	
Work Address				
City	State		Zip Code	
How did you hear about us? Friend	Doctor	Other		

PRIMARY INSURANCE INFORMATION

Policy Holder's Name	Birthdate	Phone Number	Employer
Policy Holder's Social Security Number		Policy Holder's Driver's License Number	
Insurance Company		Insurance Type (circle one) HMO PPO POS EPO	
Group Number		Policy Number	

SECONDARY INSURANCE INFORMATION

Policy Holder's Name	Birthdate	Phone Number	Employer
Policy Holder's Social Security Number		Policy Holder's Driver's License Number	
Insurance Company		Insurance Type (circle one) HMO PPO POS EPO	
Group Number		Policy Number	

EMERGENCY CONTACT INFORMATION

Name of Friend or Relative	Relationship to Patient	Phone Number
Address		

OPTIMUM WOMEN'S CARE

Nancy A. Magsino, M.D., FACOG

RELEASE OF RECORDS

I hereby authorize the release of any medical information obtained and documented by Optimum Women's Care during my course of treatment to my insurance carrier.

_____ _____

Signature Date

FINANCIAL RESPONSIBILITY STATEMENT

I hereby authorize my insurance benefits to be paid directly to Optimum Women's Care. I realize that I am responsible for paying the co-pays, deductible, co-insurance and non-covered services as determined by my insurance carrier. Furthermore, I hereby verify that I have no other insurance than the carriers listed.

_____ _____

Signature Date

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND INFORMATION RELEASE

Patient Name	Medicare ID Number

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Optimum Women's Care for any services furnished me by Dr. Nancy Magsino. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature Date

OPTIMUM WOMEN'S CARE

Nancy A. Magsino, M.D., FACOG

ALLERGIES

DRUG	REACTION

MEDICATIONS

DRUG	DOSE	How Often is This Taken?

OBSTETRIC HISTORY

Please list all pregnancies, including miscarriages and terminations.

Date of Delivery	Sex	Week's Pregnant	Baby's Weight	Hours in Labor	C-section or vaginal	Hospital	Complications

GYNECOLOGICAL HISTORY

Last Pap Smear	Any Abnormal pap smears?	Details
Last Mammogram	Any Abnormal mammograms?	Details
Any Problems with Period?	Details	
Sexually Active?	Current Birth Control	Date of Last Period

PERSONAL MEDICAL HISTORY

Please CIRCLE all that apply to YOU.

Asthma	Lung Disease/Pneumonia	Diabetes	Heart Murmur
Cancer	Thyroid Disease	Ulcer/Bowel Disease	Migraine Headache
Heart Attack/Stroke	Tension Headache	Blood Clot	Glaucoma
Hypertension	Kidney Infection (Pyelonephritis)	Lupus	Liver Disease
Kidney Stone	Other (please list)		

Details

OPTIMUM WOMEN'S CARE

Nancy A. Magsino, M.D., FACOG

SURGICAL HISTORY		
Surgery	**Date**	**Reason for Surgery**

FAMILY MEDICAL HISTORY	
Disease	**Family Member(s) affected (paternal grandmother, maternal aunt, brother, etc.)**
Cancer (type)	
Diabetes	
Hypertension	
Thyroid Disease	
Heart Disease	
Blood Clot	
Other	

SOCIAL HISTORY	
Do you smoke?	**Number of cigarettes per day**
Do you drink alcohol?	**Number of drinks per day or week**
Do you use recreational drugs?	**Please list**

MENTAL HEALTH HISTORY
Please describe any current or past mental health problems.

COMMUNICABLE DISEASES			
Disease	**Date Diagnosed**	**Disease**	**Date Diagnosed**
Gonorrhea		**Herpes**	
Chlamydia		**Hepatitis B / C**	
Syphilis		**HIV**	
Other			

REASON FOR VISIT