Women's Pelvic Surgery of North Jersey, LLC

The Most Advanced Technology and Least Invasive Surgical Solutions

Khashayar Shakiba, MD, FACOG
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INTAKE FORM

PATIENT INFORMATION

PATIENT NAME: ______________________________ AGE: ___ BIRTH DATE: ____________ SOCIAL SECURITY#______________

ADDRESS: ____________________________________CITY:______________________ STATE: ________ ZIP: ______________

HOME PHONE: (___) _______________________ CELL PHONE: (___) ___________________

EMAIL: ____

EMERGENCY CONTACT: ________________________ RELATIONSHIP: _____________ PHONE: ____________________________

EMPLOYER: _________________________________ OCCUPATION: _________________________ PHONE: ___________________

EMPLOYER ADDRESS: ______________________________ CITY: _________________ ST: ___________ ZIP: _______________

IS IT OK TO LEAVE A DETAILED MESSAGE ON YOUR PHONE? __YES __ NO CELL? __ YES __ NO

PREFERRED LANGUAGE: ______________ MARITAL STATUS: S M D OTHER

RACE:

WHITE ___ AMERICAN INDIAN OR ALASKAN NATIVE ___ ASIAN ___ BLACK OR AFRICAN AMERICAN ___ HISPANIC ___ OTHER ___

HOW DID YOU HEAR ABOUT OUR PRACTICE: ____

SPOUSE GUARDIAN INFORMATION:

NAME: ___________________________________ BIRTH DATE: _____________________ SOCIAL SECURITY: _________________

ADDRESS IF DIFFERENT: _____________________________ CITY____________________ST________ZIP__________________

PHARMACY ______________________ PHONE _______________________ CITY ___________________ ZIP CODE ____________

PRIMARY CARE DOCTOR: ______________________________ PHONE: ________________________ FAX: ____________________

INSURANCE INFORMATION

PRIMARY INSURANCE: __________________________ SUBSCRIBER NAME: _____________________________

SUBSCRIBER DATE OF BIRTH: __________________

SECONDARY INSURANCE: __________________________ SUBSCRIBER NAME: __________________________

SUBSCRIBER DATE OF BIRTH: ___________________

THIS INFORMATION I HAVE SUPPLIED ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS FORMS FOR THE PAYMENT OF MEDICAL BENEFITS FOR THE SERVICES RENDERED. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO MY PHYSICIAN FOR THE SERVICES RENDERED.

SIGNATURE OF PATIENT: _______________________________________ DATE: ______________________________

SIGNATURE OF GUANTOR: ______________________________________ DATE: ______________________________

Women's Pelvic Surgery of North Jersey, LLC

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NJ License #MA08288700 NPI # 1114121571

SCREENING QUESTIONNAIRE

Name ________________________________ Date ______________

Please circle "Yes" or "No"

1. Do you have heavy periods? Yes No

2. Do you have pain with periods? Yes No

3. Do you have pain with intercourse? Yes No

4. Are you interested in permanent contraception? Yes No

5. Do you have fibroids? Yes No

6. Do you ever leak urine? Yes No

7. Do you leak urine with a strong urge on the way to the bathroom? Y / N

8. Do you leak urine when you cough, sneeze, laugh, lift, exercise? Y / N

9. Do you wear pads to protect your clothes from urine leaking? Y / N

10. Do you urinate frequently during the day Yes No

11. Do you wake up at night to urinate? Yes No

12. Are you interested in a Diet Program? Yes No

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