PATIENT INFORMATION

Patient Name _____

Address _____ City _____ State ____ Zip _____

Telephone# _____ Date of Birth _____

S.S.# _____ Drivers License # _____

Email _____ Cell phone# _____

Employer _____ Work phone# _____

Married ___ Single ___ Divorced ___ Separated ___ Widowed ____

Spouse's Name (guardian if a minor) _____

Spouse's Employer _____ Work phone# _____

NEAREST RELATIVE NOT LIVING WITH YOU

Name _____ Phone# _____

Address _____ City _____ State ____ Zip _____

Emergency Contact _____ Phone#_____

INSURANCE INFORMATION

Insurance Name _____

ID# _____ Group# _____

Name of Policy Holder _____ SS# _____

Date of Birth _____

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF ALL MEDICAL SERVICES RENDERED TO ME AND FILED ON MY BEHALF TO BE MADE DIRECTLY TO THE PROVIDER, NAGAMANI RAO, MD, PA. I UNDERSTAND THAT VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. I AM RESPONSIBLE FOR ANY SERVICES DETERMINED TO BE PRE-EXISTING OR OTHERWISE NOT COVERED BY MY INSURANCE PLAN.

Signature **Date**

Patient Information Sheet

PATIENT NAME _____

Age _____ Single _____ Married ____ Widowed _____ Separated ____ Divorced _____

Occupation _____ Employer _____

Date of last Pap smear _____ Date of last menstrual period _____

How many pregnancies have you had? _____ How many abortions: _____ Live births? ____

How old were you at the time of your first period: _____ How many days are your periods? _____

What type of contraception do you presently use? _____

Length of time you have used this method _____

Have you ever had problems with using birth control? YES NO (Circle one)

If yes, please explain _____

Are your periods: HEAVY NORMAL LIGHT (Circle one)

What is the interval between periods? _____ Any pain during your period? _____

Do any of the following apply:

Pain during intercourse YES NO

Pain with urination YES NO

Loss of urine when coughing or sneezing YES NO

Have you ever been hospitalized? YES NO

If yes , please provide dates and reason _____ _

Any allergies to medication? YES NO If yes, please list _____

What medications are you currently taking: _____

Do you smoke? YES NO If yes, how much _____

Alcohol use YES NO If yes, how much _____

Any family history of the following: High blood pressure Cancer Other _____

What problem are you seeing Dr. Rao for today? _____