Walter R. Wolfe, M.D.

Obstetrics and Gynecology

Dominican Plaza
970 Lakeland Drive, Ste 43
Jackson, MS 39216
601-200-8201

PATIENT INFORMATION RECORD

(PLEASE PRINT OR WRITE LEGIBLY)

DATE:

PATIENT'S NAME (LEGAL)	MARITAL STATUS S M W D SEP	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.

PATIENT'S ADDRESS	CITY, STATE, AND ZIP CODE	HOME PHONE NO.
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT) HOW LONG?	BUSINESS PHONE
EMPLOYER'S STREET ADDRESS	CITY, STATE, AND ZIP CODE	CELL (OPTIONAL)

SPOUSE'S NAME	SPOUSE'S SOC. SEC. #	SPOUSE'S D.O.B.	AGE

SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT) HOW LONG?	BUSINESS PHONE
EMPLOYER'S ADDRESS	CITY, STATE, AND ZIP CODE	CELL (OPTIONAL)

REFERRED BY
NEAREST RELATIVE NOT LIVING WITH PATIENT

FOR EMERGENCY, CONTACT NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE	HOME PHONE NO.
FOR EMERGENCY, CONTACT NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE	HOME PHONE NO.

INSURANCE INFORMATION

☐ PRIVATE INSURANCE ☐ PRIVATE PAY ☐ MEDICAID ☐ MEDICARE

In order to control our costs of billing, we request that office visits be paid at the time service is rendered.

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance and any other health plan to Walter R. Wolfe, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this statement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment and/or complete disability, insurance or FMLA forms. I agree to pay court cost and legal fees if account is turned into collections.

COMMUNICATIONS REGARDING MY ACCOUNTS:

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

SIGNED: ______________________________ DATE: ____________________

WELCOME!!!!!!! NAME______________________________

Briefly describe the reason for today's visit:

____

When was your last physical exam?__________

When was your last pap smear?__________ Was it normal? _____

Have you ever had an abnormal pap smear?_____ When?________

When was your last menstrual period?__________

How often do you have your period?__________

Are you sexually active?__________________

What method of birth control do you use?

____

Have you ever been pregnant? Yes or No

If yes, how many times?__________________

How many children do you have?____________

Did you deliver vaginally or by C-Section?

____

Have you ever had a miscarriage, abortion or ectopic pregnancy? Yes or No
If yes, Explain______________________

Have you ever had surgery? Yes or No
If yes, Explain______________________

Have you ever been hospitalized? Yes or No
If yes, Explain______________________

Are you allergic to any medications? Yes or No
If yes, Explain______________________

What Medications (if any) do you take everyday

____

IF YOU HAVE HAD A TUBAL LIGATION
PLEASE PROVIDE THE YEAR __________

Do your parents, grandparents, aunts, uncles, siblings, or children have any of the following?

Cancer	Yes	or	No
Diabetes	Yes	or	No
Heart Disease	Yes	or	No

Anemia	Yes	or	No
Clotting disorder	Yes	or	No
Blood transfusion	Yes	or	No
HIV	Yes	or	No
Breast lump	Yes	or	No
Painful periods	Yes	or	No
Chlamydia	Yes	or	No
Diabetes	Yes	or	No
Endometriosis	Yes	or	No
Genital Warts	Yes	or	No
Gonorrhea	Yes	or	No
Heart disease	Yes	or	No
Lung disease	Yes	or	No
Hepatitis	Yes	or	No
High blood pressure	Yes	or	No
Incontinence	Yes	or	No
Ovarian cysts	Yes	or	No
Hot Flashes	Yes	or	No
Pelvic infection	Yes	or	No
Infertility	Yes	or	No
Thyroid problems	Yes	or	No
Cancer	Yes	or	No
Colposcopy	Yes	or	No
Cryosurgery	Yes	or	No
Laser Surgery	Yes	or	No
Syphilis	Yes	or	No
DES Exposure	Yes	or	No
Epilepsy	Yes	or	No
Kidney Disease	Yes	or	No
Eating Disorder	Yes	or	No

Genetic Screening

Patient Name: ______________________________

Pharmacy: ___________ Location: _________

Answer YES or NO to all that apply to you:

1. Down Syndrome ________
2. Neural Tube Defect ________
3. Congenital Heart Defect ________
4. Sickle Cell Disease or Trail ________
5. Hemophilia ________
6. Muscular Dystrophy ________
7. Cystic Fibrosis ________
8. Huntington Chorea ________
9. Mental Retardation/Autism ________
10. Maternal Metabolic Disorder ________
11. Recurrent Pregnancy loss/still birth ________
12. Previous child with a birth defect ________
13. Other abnormalities ________

What is your ethnic origin?________________________

When was your last menstrual period?________________

Infection Screening

Have you had a rash or viral illness since your last menstrual period? Yes or No

If yes, please explain_______________________________________

Do you have a cat(s) Yes or No

Have you had chicken pox? Yes or No

Have you had X-rays taken since your last menstrual period? Yes or No

If yes, please explain_______________________________________

List all medications you have taken since your last menstrual period:

____

Do you drink? Yes or No (Circle One) How much?_____per day

Do you smoke? Yes or No (Circle One) How much?_____per day

Do you use drugs? Yes or No (Circle One) Type_______________