Leigh Anne Massey, MD, FACOG
Angela C. Thompson, DNP, BC-FNP

NAME _____Date of Birth _____Today's Date _____

Would you please help us in updating your health information?

1. Reason for visit today:
   - ☐ Routine annual gynecological exam
   - ☐ Problem
   - ☐ Routine annual gynecological exam and problem

2. What was the first date of your last menstrual period? _____

3. Please list any new medical illnesses since your last visit:

_____

_____

_____

4. Please list any surgeries you have had since your last visit:

_____

_____

_____

5. Please list all medications you are currently taking:

Medication	Dosage

6. Please list all medication allergies you have:

_____

_____

_____

7. Please list any environmental/food allergies you have:

_____

_____

_____

8. Do you smoke? ☐ NO ☐ YES

9. Who is your primary care physician? _____ Would you like a copy of today's office visit note sent to him/her? ☐ NO ☐ YES

Leigh Anne Massey, MD, FACOG
Angela C. Thompson, DNP, BC-FNP

NEW PATIENT

NAME _____Date of Birth _____Today's Date_____

Welcome to our office! Would you please assist us in gathering your health information by answering the following questions?

1. What is the reason for your visit today?
   - ☐ Problem_____
   - ☐ Routine annual gynecological exam
   - ☐ Routine annual gynecological exam and problem

2. What was the first date of your last menstrual period? _____

3. What medications are you currently taking?

Medication	Dosage

4. What medication allergies do you have?

_____

5. What environmental/food allergies do you have?

_____

6. What are your current medical illnesses (such as diabetes, high blood pressure, etc.)?

_____

_____

_____

7. What surgeries have you had?

Surgery	Date

8. Do you smoke? ☐ NO ☐ YES

9. Who is your primary care physician? _____ Would you like a copy of today's office visit note sent to him/her? ☐ NO ☐ YES

PATIENT REGISTRATION

Patient Name: Last_____ First_____ M.I._____ ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Address: City: State: Zip:

Birthdate: ___/___/___ Age: Social Security Number:__ __ __- __ __- __ __ __ __

Race: Ethnicity: Language:

Home Phone: (____) _____- _____ Cell:(____)_____- _____ Work:(____)____- _____

Employer:

Emergency Contact: Phone:(____)_____-_____ Relationship:

Primary Care Physician: Referred by:

Do you use a local or mail order pharmacy? ☐ Local ☐ Mail order ☐ Both

Name of pharmacy: _____ Location:_____

Name of pharmacy:_____ Location:_____

☐ Check this box to give our office permission to send test results via a secure email address.

Email Address:

Please complete the following information based on the ACTUAL INSURANCE HOLDER. (spouse,parent,etc.)
Please allow our staff to make a copy of your insurance card when you return this form to the front desk. Thank you.

Primary Insurance Information

Insurance Name:_____

Name:_____

SSN: / /_____

Date of Birth: / /_____

Effective Dates:_____

Policy/ID number:_____

Group Number:_____

Secondary Insurance Information

Insurance Name:_____

Name:_____

SSN: / /_____

Date of Birth: / /_____

Effective Dates:_____

Policy/ID number:_____

Group Number:_____

Patient Signature:_____ Date:___/___/_____
(Parent or guardian if patient is unable to sign)

Leigh Anne Massey, MD, FACOG
Angela Thompson, DNP, BC-FNP
GYNECOLOGY

Our staff will do its best for you with appointment reminders and test results. Please help us by providing the phone number(s) and email address (optional) where we may reach you during regular business hours.

Name:_____ **DOB:**_____

Please use this number for reminder calls:_____

Please use number for test results:_____
(Please note actual test results will not be left on an answering machine or voicemail.)

☐ Yes, it is ok to contact me with my test results via secure email.

☐ No, please do not contact me with test results via secure email.

_____
Email address

If it is ok to give test results to any other person besides yourself please fill in the following information. If this portion is not filled out we are unable to speak with anyone but yourself regarding any of your information.

Person(s) with whom we are able to speak to:_____

Relationship to the patient:_____

Signature of patient only:_____

Date signed:_____