Diegmann & Henderson OBGYN P.C.

Chart#_____ ***Date: _____***

Name: _____/ _____/_____/_____
Last First Middle Maiden

_____/_____/_____/_____
Mailing Address City State Zip

Home #_____ Work #_____ Cell#_____

*If you would like reminders via text please list your cell phone COMPANY: _____

Marital Status (Circle One): S M W D Sep. ***Race: _____***

SSN: _____-_____-_____ Date of Birth: _____ Age: _____

Preferred Pharmacy: _____ Email Address: _____

Employer: _____

Referred by: _____

Spouse Information

Name of Spouse: ***_____ Date of Birth: _____***

Employer: _____ Work #_____

SSN: _____-_____-_____

Insurance Information

1st Insurance Co.: _____ Contract #:_____

Group #: _____

Subscriber's Name: _____ DOB: _____

2nd Insurance Co.: _____ Contract #: _____

Group #: _____

Subscriber's Name: _____ DOB: _____

_____

Emergency Contact: _____ Phone # _____

I have received a copy and will comply with Diegmann & Henderson OBGYN P.C. office policies.

Signature: _____ Date: _____

Diegmann & Henderson OBGYN P.C.

Name:	Date:	Chart #:

MENSTRUAL HISTORY: **Age Started:**_____

Regular ☐ **Irregular** ☐ **| Length of Flow:** _____**(Days) | Cramps** ☐ **Clots** ☐ **Headaches** ☐

Date of last Pap Smear: _____ **Normal** ☐ **Abnormal** ☐	**History of Abnormal Pap Smears?** _____

PERSONAL MEDICAL HISTORY/MAJOR ILLNESSES:

NONE		Hepatitis		Crohn's		BL Transfusion		Sickle Cell	
Heart		Asthma		Ulcers		Epilepsy		Phlebitis	
Arthritis		Cancer		STD		High BP		Varicose Veins	
Migraines		Diabetes		Thyroid		Anemia		Other	

SURGICAL HISTORY: **Date:**	**Type of Operation:**

PREGNANCY HISTORY: (List the # of times you have had the following. *including currently*)

Pregnant		Full-term Delivery		Stillborn		Premature Delivery		Miscarriage	
Abortion		Living Children		Infant Death		C-Section		Other	

List ALL Pregnancies IN ORDER: (Include abortions, miscarriages, etc.)

Sex:	Birth Weight:	Date of Birth:	RhoGAM:	Complications Before or After Delivery:

Diegmann & Henderson OBGYN P.C.

**Please list all prescription and over the Counter medications that you take.

MEDICATION LIST

Fred F. Diegmann, M.D.
Bret T. Henderson, M.D.

MEDICATION NAME:	DOSE:	FREQUENCY:

Diegmann & Henderson OBGYN P.C.

Fred F. Diegmann, M.D.
Bret T. Henderson, M.D.
150 South Ingleside St. Suite 2
Fairhope, AL 36532
(251) 990-6550

CONSENT FOR USE AND DISCLOUSER OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT, AND HEALTH CARE OPTIONS:

By signing below I, _____, hereby give my consent for the practice listed above, and it's allowed associates, to contact me by using any telephone numbers (including mobile phones), email addresses, and text messaging I have listed in my medical chart. I allow them to use or disclose information about myself (or another person for whom I have authority to sign for) that is protected under federal law, for purpose of treatment, appointment reminders, payment, collections, and other health care operations.

I certify that I have read the Notice of Privacy Practices for PHI by signing this consent. I understand that the terms of the Notice my change at any time and I am responsible to request an updated version if needed.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Witness Date

PERMISSION TO RELEASE HEALTH INFORMATION:

In the event that our office is unable to reach you (the patient) directly concerning (but not limited to) test results, pathology reports, and other medical information, it is up to your discretion with whom we may share this information with. Please refer to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) with any questions.

By signing below you indicate that this consent extends to the person(s) that you (or persons that you have the authority to sign for) have selected and listed below, indefinitely from the date listed on this consent, unless otherwise changed by you in writing:

☐ **Myself and those listed below:**

1. Full Name: _____ 2. Full Name: _____
   Phone #: _____ Phone #: _____

☐ **Myself Only**

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Witness Date