Bruce Crawford, M.D. / Patricia Yost, M.D.

THE FOLLOWING IS NECESSARY FOR BILLING AND COLLECTION AND WILL BE UPDATED ANNUALLY

Patient Name_____ Birth Date_____/_____/_____

Social Security Number: _____ Marital Status: Single / Married / Divorced / Widowed

Mailing Address_____

City_____ State_____ Zip_____

Phone_____ Alternate Phone_____

Email_____ Preferred Language_____

Please circle one for Ethnicity: Hispanic / Non -Hispanic decline to report

Please circle one for Race: White/African American/Black /Asian/ Pacific Islander/American Indian or

Emergency Contact_____ Phone Number_____

Preferred Pharmacy_____ Pharmacy Location_____

Preferred Laboratory (circle one): Renown / Lab Corp / Quest

It is the patient's responsibility to be aware of the preferred lab within their insurance coverage.

Primary Insurance _____ Policy ID Number_____

Policy Holder's Name_____

Policy Holder's Birth Date_____ Relationship to Policy Holder_____

Secondary Insurance _____ Policy ID Number_____

Policy Holder's Name_____

Policy Holder's Birth Date_____ Relationship to Policy Holder_____

FINANCIAL AGREEMENT

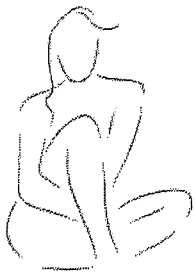
I understand that I am financially responsible for all charges for services rendered to myself. I hereby authorize Bruce Crawford, MD or Patricia Yost, M.D. to furnish my insurance carrier all information which is requested concerning my diagnosis and treatment for payment purposes. I hereby assign to Bruce Crawford, MD or Patricia Yost, MD all monies from my insurance carrier for services rendered. I understand and acknowledge that I am responsible to for my deductibles and charges not covered or not required to be discounted by this agreement.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

GUARDIAN SIGNATURE IF PATIENT IS A MINOR DATE



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experience special care

Acknowledgement of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of said Practices. *You may refuse to sign this form.*

Family & Friends Release of Information

List family and friends, *if any,* whom we may inform about your general medical condition and your diagnosis

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ I do not want my medical condition discussed with any family or friends

By signing this I confirm that I have received a Notice of Privacy Practices and recognize that Gyn Specialists of Reno can release my medical information to the individuals designated above:

Print Name:_____

Sign Name:_____

Date:_____

Written Acknowledgement was Not Obtained:

- ☐ Patient Refused to sign
- ☐ Emergency Situation
- ☐ Unable to communicate with patient
- ☐ Other_____

BRIEF HISTORY

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Name_____ Birth Date_____

Please help keep us up to date in your care by providing the following:

Current Primary Care Physician:

_____

Other Providers You See:

_____

Have you had any serious illness, operations, injuries or been hospitalized since your last visits with us?

_____

_____

_____

Has there been any changes/updates to your family history? (i.e.-cancers, heart disease)

_____

_____

_____

Are you here today for a routine annual exam? Y/N ____ New Problem? Y/N____

If you are here for a new problem please explain briefly your symptoms

_____

_____

_____

Have you had changes to any medications you are taking? Y/N_____

Have you had any lifestyle changes (smoking, drinking, drug use) or occupations changes since our last visit? Y/N____ If yes, please explain below:

_____

_____

Please be advised: If you are over the age of 40, a Fecal Occult Blood (FOB) test will be performed during your annual exam in order to screen for blood in your stool. This test may or may not be covered by your insurance and the total cost is $28.00

BRIEF HISTORY

REVIEW OF SYSTEMS - *Are you experiencing any of the following symptoms?*

CONSTITUTIONAL

- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Weight Change + or –
- ☐ Weakness
- ☐ Fatigue

EYES

- ☐ Change in Vision

EAR, NOSE, MOUTH, THROAT

- ☐ Change in hearing
- ☐ Nosebleeds
- ☐ Sore Throat
- ☐ Dry Mouth

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Shortness of Breath
- ☐ Chest pain
- ☐ Loss of consciousness
- ☐ Palpations

RESPIRATORY

- ☐ Chest pain
- ☐ Cough – productive or dry
- ☐ Shortness of breath
- ☐ Wheezing

GASTROINTESTINAL

- ☐ Abdominal Pain
- ☐ Nausea, vomiting
- ☐ Change in bowel habits
- ☐ Change in appetite
- ☐ Dark or bloody stool
- ☐ Indigestion
- ☐ Constipation or diarrhea

ENDOCRINE

- ☐ Weight change
- ☐ Excessive thirst, urination
- ☐ Tremor
- ☐ Cold or heat intolerance

GYNECOLOGICAL

- ☐ Bleeding or pain with intercourse
- ☐ Unusual vaginal discharge or odor
- ☐ Vulvar or vaginal itching or burning
- ☐ Pelvic pain

HEMATOLOGICAL/LYMPHATIC

- ☐ Swollen lymph glands
- ☐ Bruise easily

URINARY

- ☐ Painful urination
- ☐ Frequent urination
- ☐ Urinary urgency
- ☐ Blood in urine
- ☐ Urinary incontinence
- ☐ Getting up at night to urinate

MUSCULOSKELETAL

- ☐ Back pain
- ☐ Weakness
- ☐ Joint pain, stiffness, swelling

INTEGUMENTARY/BREAST

- ☐ Nodules
- ☐ Change in moles, freckles, texture
- ☐ Breast lumps
- ☐ Breast nipple discharge
- ☐ Breast pain

NEUROLOGICAL/PSYCHIATRIC

- ☐ Memory change
- ☐ Depression
- ☐ Anxiety
- ☐ Mood swings
- ☐ Numbness or tingling

Thank you for taking the time to answer these questions.