



**Jenkins Ob-Gyn
& Reproductive
Medicine**

Patient Name _____ Drivers Lic # _____

Address: _____ City, St, Zip _____

Telephone: Home (_____) _____ Work (_____) _____

E-mail Address: _____

I am aware that periodically, I may receive e-mails from Jenkins Ob/Gyn and Reproductive Medicine.

Check One: Employed____ F/T Student _____ P/T Student _____ Unemployed _____

Check One: Single _____ Married _____ Other _____

Patient	Spouse/Parent (If minor)
Employer/School_____	Name_____
Emp/Sch Address _____	Work Number _____
SS# _____	SS# _____
Date of Birth _____	Date of Birth_____

Name of Emergency Contact and Phone #: _____

Relative or Friend not living at same address:

Name: _____ Relationship _____

Address _____ Phone Number _____

Primary Insurance:	Secondary Insurance:
Ins Co: _____	Ins Co: _____
Policy/ ID #: _____	Policy/ ID #: _____
Group #: _____	Group #: _____

Assignment of Insurance Benefits and Authorization to Release Information:

I authorize payment of medical benefits to T.L. Jenkins, M.D., P.A. for any and all services not paid in full at the time those services are rendered. I authorize T.L. Jenkins, M.D, P.A. to release any medical information as may be necessary for the completion of my insurance claims to any insurance carrier, health or hospital plan.

Patient Signature _____ Date _____

Patient's Legal Guardian/Parent _____ Date _____

Past History: Circle all that apply

Arthritis	High Blood Pressure	Pneumonia	Rheumatic Fever
Asthma	Breast Problems	Migraine Headaches	Thrombophlebitis
Diabetes	High Cholesterol	Mitral Valve Prolapse	Thyroid Problems
Heart Attack	Intestinal Bleeding	Neurological Disease	
Heart Murmur	Kidney Infection	Osteoporosis	
Hepatitis	Kidney Stone	Paralysis	

Other Medical Problems: _____

List all surgeries:

Type of surgery	Approximate Date	Type of Surgery	Approximate Date
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Number of:

____ Pregnancies ____ Deliveries ____ Miscarriages ____ Abortions ____ Living children

Please list ALL previous pregnancies in chronological order:

Year	Sex	Wt	Anesthesia	Complications
____	____	____	Vaginal or Cesarean	_____
____	____	____	Vaginal or Cesarean	_____
____	____	____	Vaginal or Cesarean	_____
____	____	____	Vaginal or Cesarean	_____
____	____	____	Vaginal or Cesarean	_____

Will you permit a blood transfusion for medical reasons? _____

Date of last menstrual period ____/____/____ Are your periods regular? _____

Any problems with periods? _____ Present type of birth control _____

Do you want to change birth control? _____ To what? _____

With respect to your female organs, have you ever had: Circle all that apply

Abnormal bleeding	Herpes Infection	Tubal (Ectopic) Pregnancy
Genital warts	Tumor of the Uterus or Ovaries	
Chlamydia/Gonorrhea/Syphilis	Infections of the Tubes or Ovaries	

Have you ever had an abnormal Pap Smear? _____ Treatment? _____

List all currently used medications:

List all allergies to medications:

Genetic: If you or your husband are in the following categories, please respond: Answer Yes or No

If of African American or Indian descent, have you or your husband had Sickle Cell carrier testing? _____

If of Italian or Greek descent, have you or your husband had Thalassemia carrier testing? _____

If of Jewish descent, have you or your husband had Tay-Sachs carrier testing? _____

Social History:

Race: _____ Occupation: _____

Do you drink alcohol? _____ If yes, estimated number of drinks per week? _____

Do you smoke? _____ If yes, how many packs a day? _____

Are you using any other drugs? _____ Type: _____

Are you sexually active? _____ Any difficulties or discomfort? _____

Family History: Is there a member of your family with a history of:

_____ Cancer – Type: _____ Who? _____

_____ Congenital(Inherited) Disease Who? _____

_____ Diabetes Who? _____

_____ Heart Disease Who? _____

_____ High Blood Pressure Who? _____

_____ High Cholesterol Who? _____

_____ Kidney Disease Who? _____

_____ Mental Retardation Who? _____

_____ Osteoporosis Who? _____

_____ Twins Who? _____

Date of last Pap Smear _____ Results _____

Date of last Mammogram _____ Results _____

Date of last Bone Density _____ Results _____

Reason for today's visit:

Name and phone number of your primary care physician:

What changes have there been in your life recently? _____

How did you hear about us?

Internet

Friend

Hospital: Memorial City Katy Christus St. Catherine Methodist

PCP: Dr. Carothers Dr. Toro Dr. Naghavi Dr. Kendall Dr. Rios

Other: _____



**Jenkins Ob-Gyn
& Reproductive
Medicine**

Patient Signature Page

Patient Name: _____ Account #: _____

Financial Responsibility

I have received, read and understand the Patient Financial Policy from T.L. Jenkins, M.D., P.A. and I further agree to be bound by the terms stated therein. I also understand and agree that T.L. Jenkins, M.D., P.A. may amend such terms from time to time.

Signature: _____ Date: _____

Name of Signee, if other than patient: _____

Relationship to the patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, the undersigned, hereby acknowledge the receipt of a copy of the Notice of Privacy Practices of T.L. Jenkins, M.D., P.A.

Signature: _____ Date: _____

Name of Signee, if other than patient: _____

Relationship to the patient: _____