



**Jenkins Ob-Gyn  
& Reproductive  
Medicine**

**Annual Patient Information Update**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Telephone: \_\_\_\_\_ Social Security # \_\_\_\_\_

E-mail Address \_\_\_\_\_

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

Check One: Employed  Student  Other \_\_\_\_\_

Check One: Single  Married  Other \_\_\_\_\_

**CURRENT INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insured Person \_\_\_\_\_ SSN # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB \_\_\_\_\_

**MEDICAL HISTORY**

Any pregnancies, deliveries, miscarriages or abortions since your last visit? Pregnancies \_\_\_\_\_

Deliveries \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_ Number of living children \_\_\_\_\_

Current Contraception \_\_\_\_\_

Current Medications \_\_\_\_\_

Medication Allergies \_\_\_\_\_

Surgery since last visit \_\_\_\_\_

Last Menstrual Period \_\_\_\_\_ Last Mammogram \_\_\_\_\_ Bone Density Test \_\_\_\_\_

Major Medical Problems or Hospitalizations since last visit \_\_\_\_\_

**Assignment of Insurance Benefits:** *I authorize payment of medical benefits to T.L. Jenkins, M.D., P.A.*

**Authorization to release information:** *I authorize T.L. Jenkins, M.D., P.A. to release any medical information as may be necessary for the complication of my insurance claim to any insurance carrier, health or hospital plan.*

**Acceptance of Financial Responsibility:** *I accept financial responsibility for any services not covered by my insurance.*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Legal Guardian/Agent \_\_\_\_\_ Date \_\_\_\_\_