



PATIENT REGISTRATION FORM 1 of 8

Hello! Welcome to our office. We are anxious to make your appointment as convenient as possible. Would you please help us by furnishing the information requested below. This will be used to complete your record and will be kept strictly confidential. Hilton I. Kort, M.D., F.A.C.O.G., Carlene W. Elsner, M.D., F.A.C.O.G., Dorothy Mitchell-Leef, M.D., F.A.C.O.G., Michael A. Witt, M.D., F.A.C.S., Daniel B. Shapiro, M.D., F.A.C.O.G., Andrew A. Toledo, M.D., F.A.C.O.G., Scott M. Slayden, M.D., and Robert J. Straub, M.D., reserve the right to assign any physician in their employ to participate in your medical care and that such assignment may be changed at their discretion. Should your address change at any time, please fill out another one of our information sheets. Should you ever need to cancel an appointment, please call and let the office know as soon as possible. If you have any questions about your care, your appointment or our fees, please feel free to discuss them with us. **THANK YOU!!**

| | |
|--------------|--------------------|
| First Name: | Home Phone: |
| Middle Name: | E-mail Address: |
| Last Name: | Social Security #: |
| Address 1: | Race: |
| Address 2: | Marital Status: |
| City: | Date of Birth: |
| State: | Country: |
| Zip: | Age: |
| Employer: | Work Phone: |
| City: | Occupation: |
| State: | Zip: |

| | |
|---------------------------|--------------------|
| Spouse's/ Partner's Name: | Home Phone: |
| Middle Name: | E-mail Address: |
| Last Name: | Social Security #: |
| Address 1: | Race: |
| Address 2: | Marital Status: |
| City: | Date of Birth: |
| State: | Country: |
| Zip: | Age: |
| Employer: | Work Phone: |
| City: | Occupation: |
| State: | Zip: |



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Nearest Relative (not living in same household)

Relationship:

Address 1:

Phone Number:

Address 2:

City:

State:

Zip

Referred By:

If Yellow Pages, (city Specific):

Doctor Name:

Phone Number:

Address 1:

Phone Number:

Address 2:

City:

State:

Zip:

Responsible Party (Complete Only If Different From Patient or Spouse)

Name:

Employed By:

Address 1:

Occupation:

Address 2:

Business Address 1:

City

Business Address 2:

State:

City:

Zip

State:

Home Phone:

Zip:

Work Phone:

Primary Insurance Company

Secondary Insurance Company

Insurance Company

Insurance Company

Insured Name

Insured Name

ID Number

ID Number

Group Number

Group Number



Ph Number for Benefits:

Ph Number for Benefits:

Ph Number for Precerts:

Ph Number for Precerts:

Claim Mailing Address:

Claim Mailing Address:

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Have you been referred to a particular physician?

If not, do you prefer a male or female physician?

If no referral or preference, would you be interested in being scheduled with the first available physician?

Physician you are requesting an appointment with?

An administrative assistant will contact you during our regular office hours:

8:30 am – 4:00 pm, Monday – Thursday

8:30 am – 3:30 pm, Friday

At which number would you prefer to be contacted?

Please indicate the physician(s) from who you have requested medical records:

1. _____

2. _____

3. _____

Address(es) of physician(s):

1. _____

2. _____

3. _____

Main reason for seeking medical attention:



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Your present Age:

Age at first period:

Weight :

Height:

The interval between first day of one period to first day of next period ranges from _____ to _____ days.

Duration of flow is:

Menstrual flow is usually:

Last menstrual period:

Previous period:

Married:

Length of Marriage:

Types of contraceptive(s)
used & approximate dates:

Length of time since
last contraception:

Surgeries:

List all operations you have had with the date and place of surgery:

1. _____
2. _____
3. _____

Please list all infertility tests you have had in the past, with results if known:

1. _____
2. _____
3. _____

Dates of deliveries of pregnancies delivered over 5.5 pound birth weight:

1. _____
2. _____

Dates of deliveries of pregnancies delivered over 1 pound and less than 5.5 pound birth weight:

1. _____
2. _____

D&C or complications:

Number & dates of miscarriages: _____

Dates of therapeutic abortions: _____

Dates of tubal pregnancies: _____

Number of living children and dates of birth: _____

Number of adopted children and ages: _____



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Have you ever had the following?

| | | | | | |
|--|-----|----|---|-----|----|
| Pain with periods | Yes | No | At other times: | Yes | No |
| Pain with sexual intercourse: | Yes | No | Sexual problems: | Yes | No |
| Herpes virus infection (genital): | Yes | No | Gonorrhea, Chlamydia, or Infection of tubes: | Yes | No |
| An abnormal Pap Smear: | Yes | No | High blood pressure: | Yes | No |
| Blood Transfusion: | Yes | No | Cancer: | Yes | No |
| Anemia: | Yes | No | Jaundice or hepatitis: | Yes | No |
| Bleeding disorder: | Yes | No | Gall bladder trouble: | Yes | No |
| Ulcer or gastrointestinal problems: | Yes | No | Blood clots or phlebitis: | Yes | No |
| Diabetes: | Yes | No | Heart murmur or lung: | Yes | No |
| Hernia: | Yes | No | Asthma or hayfever: | Yes | No |
| Arthritis, bone or joint problems Including injuries: | Yes | No | Kidney stones: | Yes | No |
| Convulsions: | Yes | No | Nervous breakdown or mental health Problems: | Yes | No |
| Varicose veins or blood clots: | Yes | No | | | |

If other, give explanation: _____

Diagnosis and Year: _____

Please explain and include year of illness for any illness you answered yes to:

Have you ever been hospitalized for any non-surgical illness? _____



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Family History

| | Age | Health | Age at Death | Cause |
|----------|------------|---------------|---------------------|--------------|
| Father | | | | |
| Mother | | | | |
| Brother | | | | |
| Brother | | | | |
| Sister | | | | |
| Sister | | | | |
| Children | | | | |
| Children | | | | |
| Children | | | | |

Has any blood relative had any of the following?

| | | | | | |
|---------------------|-----|----|-----------------------|-----|----|
| Diabetes | Yes | No | Cancer | Yes | No |
| Birth Defects | Yes | No | Mongolism or other | Yes | No |
| Sickle Cell Disease | Yes | No | Genetic Disorder | Yes | No |
| Infertility | Yes | No | Recurring Miscarriage | Yes | No |



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Check any of the following that you now have or which have been present in the last six months:

Headaches

Lumps in breasts or
Nipple discharge:

Any problems of the eyes,
ears, nose or throat

Numbness or tingling

Do you wear contacts or
glasses

Nausea or vomiting/ vomiting
blood

Do you have dentures which
are removable

Diarrhea

Chronic cough or coughing
blood

Chest Pain

Shortness of breath

Swelling in hands, feet, ankles
or calf tenderness

Back pain

Joint pain

Hot flashes or sudden
sensation of feeling hot

Loss of consciousness,
fainting or seizure

Irregular or rapid heartbeat

Anxiety or depression

Weight gain or loss in past
year _____lbs

Elaborate if needed:

Have you been tested for immunity to Rubella? Yes No

Did your mother take estrogen therapy during her pregnancy? Yes No

(For Black Patients)

Would you like to be tested for sickle cell disease? Yes No

(For Jewish Patients)

Would you like to be tested for Tay Sach's? Yes No

Drug reactions or allergies:

Type of reaction:

Current medications:

Have you had sexual contact with a homosexual or bisexual man or anyone using intravenous drugs? Yes No

