



# PATIENT INFORMATION

Patient Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Birthday: \_\_\_\_\_

Retired: \_\_\_\_\_ Employed: \_\_\_\_\_ Full Time Student: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Security: \_\_\_\_\_ Drivers License: \_\_\_\_\_

Person responsible for account: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Birthday: \_\_\_\_\_

Retired: \_\_\_\_\_ Employed: \_\_\_\_\_ Full Time Student: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Security: \_\_\_\_\_ Drivers License: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

(Outside Your Home)

Relatives of friends that are patients: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Major Medical Problems: \_\_\_\_\_

Have you arranged for a Living Will? (Advanced Directive)  Yes  No Have you appointed a durable power of attorney?  Yes  No

## INSURANCE POLICY INFORMATION

Insurance Company (Primary): \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer: \_\_\_\_\_ Co-payment amount: \$ \_\_\_\_\_

Group Number: \_\_\_\_\_ Contract Number: \_\_\_\_\_

Relationship of patient to policy holder: \_\_\_\_\_

Insurance Company (Secondary): \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer: \_\_\_\_\_ Co-payment amount: \$ \_\_\_\_\_

Group Number: \_\_\_\_\_ Contract Number: \_\_\_\_\_

Relationship of patient to policy holder: \_\_\_\_\_

Referred by: \_\_\_\_\_

Where did you hear about Trinity OB/GYN:

- Internet/Web Search
- Word-of-Mouth (Friend/Neighbor)
- Print Advertising
- Other (Please explain below)

Other: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



Mary B. Adams, M.D.  
James C. Brock, M.D.  
Lindsay Killingsworth, M.D.  
Wm. Andrew Lemons, Jr., M.D.  
Natalie Reddington, D.O., M.P.H.  
Lewis R. Schulman, M.D.

## Non-Covered Service Agreement

As your physician, I want to provide you with the best care possible. There may be certain routine services performed during your visit(s), such as:

Dexa Scans	Pap Smears	Biopsies
Ultrasounds or X-rays	Lab Work	Injections

and/or other testing that I feel necessary for the maintenance of your good health and that may NOT be covered by your insurance contract. You will be expected to pay for these services.

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

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

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

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

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

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

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



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## Authorization for the Release of Patient Information

\_\_\_\_\_ **I DO NOT** wish to have test results or other medical information released to any person other than myself.

\_\_\_\_\_ **I DO** wish to have test results or other medical information released to the following person(s):

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Name	Relationship
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Name	Relationship
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Name	Relationship
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Name	Relationship
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*It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must file another Authorization for Release of Patient Information with this clinic.*

Please understand that it may be necessary for us to disclose some or all of the Information contained in your medical records to other physicians, nurses, and/or healthcare providers (collectively referred to as "providers"). At times, other providers assist using assessing a patient's condition, screening for potential problems, or providing consultation under certain circumstances. All healthcare providers are required by law to maintain your patient confidentiality.

Also, due to the increased awareness of quality care and outcome measurements, it may be necessary to disclose information regarding your care to healthcare agencies (both private and governmental), your insurance company and/or your self-insured employer. Regarding the information going to your employer, other than information needed to verify your insurance coverage, the data released will consist of statistical information only.

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Patient Signature	Date
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Printed Name	SS#
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# Patient History Intake

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referred by: \_\_\_\_\_

Please describe the reason(s) for this visit:      Annual exam    or    Problem visit

List any medications you are taking, including non-prescription drugs, vitamins, and herbals:

Any drug allergies: \_\_\_\_\_

## Review of Systems:

Do you have now of have you had persistent symptoms within the past year?

Const	Weight gain/loss.....	no	yes	Chest pain.....	no	yes	Previous kidney/bladder infection.....	no	yes
	Fever.....	no	yes	Rapid heart beat.....	no	yes	Psych Depression.....	no	yes
	Fatigue.....	no	yes	Swollen hands/feet.....	no	yes	Mood swings.....	no	yes
Eyes	Dry eyes.....	no	yes	Painful breasts.....	no	yes	Overwhelming anxiety.....	no	yes
	Vision changes.....	no	yes	Breast lumps.....	no	yes	MSK Joint or muscle pain.....	no	yes
ENT	Mouth sores.....	no	yes	Nipple discharge.....	no	yes	Muscle weakness.....	no	yes
	Sore throat.....	no	yes	GI Persistent diarrhea.....	no	yes	Lymph Swollen Lymph nodes.....	no	yes
	Ringing in ears.....	no	yes	Bloody stools.....	no	yes	Neuro Seizures.....	no	yes
	Sinus headaches.....	no	yes	Nausea/Vomiting.....	no	yes	Frequent headaches.....	no	yes
Resp	Persistent cough.....	no	yes	Constipation.....	no	yes	Dizziness.....	no	yes
	Coughing blood.....	no	yes	Bloating/Gas.....	no	yes	Numbness.....	no	yes
	Wheezing.....	no	yes	Abdominal pain.....	no	yes	Heme Easy bleeding.....	no	yes
CV	Shortness of breath.....	no	yes	All Hives, blisters.....	no	yes	Easy bruising.....	no	yes
	Shortness of breath with activity.....	no	yes	Renal Pain or burning with urination.....	no	yes	Endo Night sweats.....	no	yes
	Difficulty breathing while lying down.....	no	yes	Strain/push to urinate.....	no	yes	Skin Skin rash.....	no	yes

## Female Genitourinary Review:

Date of last pap smear _____	History of Herpes.....	no	yes	Painful periods.....	no	yes
Any abnormal paps.....	Gonorrhea.....	no	yes	Clotting with periods.....	no	yes
Date of last mammogram _____	Trichomonas.....	no	yes	Any problem w/leaking urine.....	no	yes
Date of last colonoscopy _____	Chlamydia.....	no	yes	<u>Menopausal patients only</u>		
Date of last bone density scan _____	Genital Warts.....	no	yes	When did your menstrual periods stop?	_____	
Currently sexually active.....	Age period began _____			Hot flashes.....	no	yes
Ever sexually active.....	Date of last period _____			Vaginal dryness.....	no	yes
Method of contraception _____	Frequency of periods _____			Vaginal bleeding.....	no	yes
	Average # of days _____			Do you use hormones.....	no	yes
Satisfied with this method.....	Flow: light moderate heavy			Ever used hormones.....	no	yes
Pain with intercourse.....	Did you breastfeed.....	no	yes	Type _____		
	Monthly breast exams.....	no	yes			

## Previous Pregnancies:

Total # of pregnancies	Total # of live births	# Miscarriages	# Abortions	# D & C
Birth Date	Birth Weight	Baby's Name	Weeks of Pregnancy	Complications
				Vaginal or C/S
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Past Medical History:**

Have you ever had the following?:

- Heart disease..... no yes
- Heart attack..... no yes
- Metral valve prolapse..... no yes
- Collagen diseases (Lupus)..... no yes
- Arthritis..... no yes
- Rheumatic fever..... no yes
- High blood pressure..... no yes
- Anemia..... no yes
- Tuberculosis..... no yes
- Diabetes..... no yes

- Gastric ulcers/reflux..... no yes
- Cancer..... no yes
- If yes, type \_\_\_\_\_
- Glaucoma..... no yes
- Asthma..... no yes
- Pneumonia..... no yes
- AIDS or HIV..... no yes
- Stroke..... no yes
- Hepatitis - liver disease..... no yes
- Kidney stones..... no yes
- Blood clots in legs..... no yes

- Blood clots in lungs..... no yes
- Bleeding tendency..... no yes
- Thyroid disease..... no yes
- Seizure disorder..... no yes
- Sleep apnea..... no yes
- Broken bones..... no yes
- Restless legs..... no yes
- Eating disorder..... no yes
- Osteoporosis..... no yes

Please list any other major medical illnesses or hospitalizations

**Past Surgical History:**

Have you ever had the following?:

- Hysterectomy..... no yes
- Partial            Complete
- Surgery for endometriosis..... no yes
- Cesarean delivery..... no yes

- Tubes tied..... no yes
- Breast biopsy..... no yes
- Surgery for ovarian cysts..... no yes
- Mastectomy..... no yes
- Bladder surgery..... no yes

- Appendectomy..... no yes
- Tonsillectomy..... no yes
- Gallbladder removed..... no yes
- Bladder tack..... no yes

Please list any other previous surgeries

**Family History:**

Has any blood relative ever had the following?:

- Breast cancer..... no yes
- Ovarian cancer..... no yes
- Colon cancer..... no yes
- Uterine cancer..... no yes
- Stroke..... no yes
- High blood pressure..... no yes

- Heart disease..... no yes
- Diabetes..... no yes
- Kidney disease..... no yes
- Tuberculosis..... no yes
- Depression..... no yes
- Thyroid disease..... no yes

- Blood clots in legs/lungs..... no yes
- Osteoporosis..... no yes
- Birth defects..... no yes
- High cholesterol..... no yes

**Social History:**

Marital Status:    S    M    W    D

Sexual orientation:    Heterosexual    Homosexual    Bisexual

Occupation: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Do you exercise?    Yes    No

Have you ever been physically abused?..... no yes

Have you ever been mentally abused?..... no yes

Have you ever been sexually abused?..... no yes

Have you ever smoked?    Yes    No    Current packs/day \_\_\_\_\_

If former smoker, date quit \_\_\_\_\_

Alcohol use (amount per week) \_\_\_\_\_

Do you use marijuana, cocaine or other illicit drugs?..... no yes

**I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.**

X \_\_\_\_\_

Signature of patient or parent if patient is a minor

\_\_\_\_\_

Date



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### Record Release Authorization

Physician and/or Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

I hereby authorize and request the release of my records to:

**Trinity OB/GYN**  
**840 Montclair Road, Suite 500**  
**Birmingham, AL 35213**  
**office: 205-592-5499 fax: 205-592-5438**

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Please send the complete medical records that are in your possession, concerning my illness and/or treatment during the period from \_\_\_\_\_ to \_\_\_\_\_.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SS #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

\_\_\_\_\_  
Witness Date