Starkville Clinic for Women

100 Medical Park Dr
Starkville, Ms 39759

Patient Information
Form # PI-101
Revised: 03/17/2023

NAME: _____ MAIDEN NAME: _____

DOB: _____/_____/_____ Race: _____ Social Security #: _____

Mailing Address: _____Apt #: _____

City: _____ State: _____ Zip code: _____

Cell Phone: _____ Work phone: _____ Alternate: _____

Marital Status: □ Single □ Married □Widowed □Divorced

Spouse Name: _____

Employer: _____

Emergency Contact and relation to you: _____

Emergency Contact Phone #: _____

Pharmacy Name: _____ Location of Pharmacy: _____

Primary Insurance: _____ Policy #: _____

Subscriber Name: _____ Subscriber DOB: _____/_____/_____

Secondary Insurance: _____ Policy #: _____

Subscriber Name: _____ Subscriber DOB: _____/_____/_____

Email: _____

*Your email will be used to sign up for our patient portal system. This will allow you to view your medical records and lab results. To sign up please follow the link provided in the invitation email that is sent by the clinic. If you have any problems with the portal system, please notify us.

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NAME: _____

PRIMARY FAMILY DOCTOR: _____

REASON FOR YOUR VISIT TODAY: ❑ Wellness Exam ❑ New Pregnancy ❑ Contraception ❑ Problem

If having a problem, please list: _____

At what age did menstruation begin? _____

What was the first day of your last menstrual period? _____/_____/_____

___ Post menopausal Year of last period: _____ Is your period usually:

How often do you get your period? _____ How many days does your period last? _____ days
(exa. Monthly, every three weeks, every 6 weeks, etc)

REPRODUCTIVE HISTORY: Check all that apply.

Are you sexually active? □ Yes □ Never □ Not currently

What do you currently use for birth control?

❑ IUD	❑ Depo Provera	❑ Tubal Ligation	❑ Partner- Vasectomy	❑ Nexplanon
❑ Condoms	❑ Nuva Ring	❑ Pills	❑ Patches	❑ None

Total number of pregnancies: _____ Number of living children: _____

Number of miscarriages/ abortions: _____

Have you ever had an abnormal pap smear? ❑ No ❑ Yes: Date of abnormal pap: _____

Have you ever had any sexually transmitted infections?

❑ Chlamydia ❑ Gonorrhea ❑ Trichomonas ❑ HIV ❑ Syphilis

❑ Herpes ❑ Genital Warts ❑ PID ❑ Hepatitis: Type: _____

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PLEASE LIST THE LAST TIME YOU HAVE HAD THE FOLLOWING:

HAS ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING? Please check all that apply.

	DATE	WHERE	RESULTS
Pap Smear			
Mammogram			
Colonoscopy			
Bone Density Scan			
Genetic Testing			

	Father	Mother	Brother	Sister	Son	Daughter	Paternal GF	Paternal GM	Maternal GM	Maternal GF
Breast Cancer										
Ovarian Cancer										
Uterine Cancer										
Cervical Cancer										
Colon Cancer										
Diabetes										
Heart Disease										
High Blood Pressure										
Strokes										
Osteoporosis										
Other:										

PLEASE LIST ANY SURGERIES AND DATES:

_____ _____

_____ _____

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PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS:

Asthma	High Cholesterol	Anxiety	Hyperthyroidism
Hypothyroidism	Blood clots	High Blood Pressure	Depression
Diabetes Type 1	Diabetes Type 2	GERD	

Other: _____

_____

SOCIAL HISTORY:

Smoking: Packs per day: ____ Years: _____

Alcohol Use: None Occasionally/Socially Regular: Drinks per day _____

Drug Use: None Present: What type: _____ How often: _____

Exercise: No Yes: What type: _____

When was your last Flu Vaccine? Date: _____ ❑ I do not receive a seasonal Flu Vaccine

Have you received the COVID vaccine? _____ If yes, dates _____ 1st dose _____ 2nd dose

_____

Are you allergic to any medications?

Allergy	Reaction

Please list all medications you currently take:

Name of medication	Dosage	Times per day

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Patient Name:	Form Name: Consent to Tx/Privacy Notice
Acct Number:	Form #: PI-102
Date:	Revised: 3/25/2021

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Starkville Clinic for Women on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

I understand that information obtained by this authorization will be used to determine eligibility for insurance and eligibility for benefits under my insurance coverage. No information will be released except to persons or organizations performing business or legal services in connection with the claim or as may be otherwise lawfully required or as I may further authorize.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I authorize that payment of medical benefits by made to Starkville Clinic for Women on any claim submitted for any services furnished to be by the clinic.

I understand that I am financially responsible to Starkville Clinic for Women for charges not covered by my insurance.

I acknowledge that I have read the posted Notice of Privacy Practices for Starkville Clinic for Women.

_____ _____

Patient Guardian

I do consent to have medical information released/disclosed to the following individuals. If this area is left blank, I do not wish to have my medical information released without my express consent.

_____ _____

_____ _____

_____ _____

Patient Guardian