Debbie A Vigil, M.D.

Please answer the following questions as best as you can so that we may better assist you with your healthcare needs.
This sheet is to be completed annually (usually at your annual exam, or if it's outdated).
Thank you, and welcome to our practice.

PATIENT INFORMATION

Date:_____ Soc. Sec #:___-___-____ Age:_____ Birth date:_____

Name:_____ Home Phone:_____

Address:_____ Cell Phone:_____

City:_____ State:_____ Zip:_____

Employer and occupation:_____ Business Phone:_____

Emergency contact:_____ Relationship:_____ Phone:_____

REASON FOR VISIT TODAY:_____

Who referred you to this office?_____

Primary Care Physician:_____ Phone Number:_____

- **List any medications, vitamins, minerals, and herbs that you are currently taking**:

  _____

  _____

  _____

  _____

- **Please list all of your allergies**:_____

GENERAL GYNECOLOGICAL HISTORY

☐ Minor ☐ Single ☐ Long Term Partner ☐ Married ☐ Divorced ☐Separated ☐ Widowed

- Date of the first day of your last menstrual period:_____ was it normal? ☐ No ☐ Yes
  Do you have a history of abnormal periods? ☐ No ☐ Yes (please explain):_____
- Date of your last pap smear:_____ was it normal? ☐ No ☐ Yes
  Do you have a history of abnormal pap smear results? ☐ No ☐ Yes (date):_____
  What treatments have you had for the previous abnormal pap(s)?_____
- Date of your last mammogram:_____ was it normal? ☐ No ☐ Yes
  Do you have a history of abnormal mammograms? ☐ No ☐ Yes (date):_____
  What treatments have you had for the abnormal mammogram(s)?_____
- Date of your last colonoscopy:_____ was it normal? ☐ No ☐ Yes
- Date of your last bone density test:_____ was it normal? ☐ No ☐ Yes

Are you sexually active? ☐No ☐Yes (☐with male ☐with female ☐with both)

Would you like to be tested for sexually transmitted diseases? ☐No ☐Yes

Current pregnancy prevention method:

☐None ☐Vasectomy ☐Tubal ligation ☐Condoms ☐Abstinence ☐Essure ☐Diaphragm ☐Patch
☐Nuvaring ☐Withdrawal ☐Rhythm ☐Sponge ☐Depo Provera ☐Cervical cap ☐Spermicide
☐Oral contraception (name):_____
☐Intrauterine device: Mirena / Paragard ☐Implantable device: Implanon / Nexplanon
Please circle type Please circle type

INSURANCE INFORMATION

NAME: _____ DOB: _____

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

Are you or your spouse/partner covered under an employer group health plan? Yes ❒ No ❒

Who is the primary plan holder for that group health plan?

Name: _____ Relationship:_____

DOB: (if not self):_____ Soc.Sec#:____-____-_____Employer:_____

Address(if different)_____

Primary Insurance: _____ ID or Policy No._____

Group No.:_____ Effective Date: _____

Secondary Ins.:_____ ID or Policy No.:_____

Group No.:_____ Effective Date:_____

Debbie A Vigil MD is a non-participant of medicare, she has opted-out of medicare. This means that neither Dr. Vigil nor you can submit a claim to Medicare. You will be obligated to pay for the services at the time they are rendered.

By signing this document, you are stating that you understand and agree to the above.

For all other insurances, do you authorize this office to file claims and receive payment for services rendered by Dr. Vigil with your insuarnce company? Yes ❒ No ❒

If you are uninsured, who is responsible for this bill?_____

_____

I will be paying today by: Cash ❒ Check ❒ Credit Card ❒

Authorization to Release Information and Assignment of Benefits

I hereby authorize payment directly to DEBBIE A. VIGIL, M.D. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependent. I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____