Jeanne F. Eddington, M.D
Robert A. Eddington, M.D
Gregory L. Berault, M.D.
Blake C. Landry, M.D.
Jessica M. Rosselot, M.D.

Patient Name _____ Date of Birth _____

Age _____ Race _____ Marital Status _____ Blood Type (if known) _____

Have you been a patient at our office before _____ If so, when_____

Current Medications (prescribed and over the counter)

MEDICATION	DOSE	FREQUENCY

Drug allergies _____

Gynecological History

What are you currently using for birth control _____

1st day of your last menstrual period _____ How many days do your periods last_____

How many pads/tampax do you use per day _____ Do you bleed in between periods _____

What age did periods begin _____ Are your menstrual cramps Mild ___ Moderate ___ Severe _____

Do you have discharge in between periods _____ What color is it _____ Any itching _____

How many times have you been pregnant _____ How many children _____ Miscarriages _____

Last Pap Smear _____ Have you ever had an abnormal Pap Smear _____ Have you had treatment for

an abnormal smear _____ if yes, what type(s) of treatment have you had_____

Date of last Mammogram: _____ Do you lose urine when you cough or sneeze _____

Other past gynecological history

None ___ Venereal warts___ Herpes – genital ___ Syphilis ___ Pelvic Inflammatory Disease ___
Endometriosis ___ Chlamydia ___ Gonorrhea ___ Vaginal infection___ Other_____

Do you have any sexual problems to discuss _____

Do you smoke _____ Drink alcohol _____ Use recreational Drugs _____

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Medical History:

- ☐ Abnormal PAP Smear
- ☐ Anemia
- ☐ Anesthetic Complications
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ Breast Problems
- ☐ Cancer
- ☐ Coronary Artery Disorder
- ☐ Diabetes
- ☐ Endometriosis
- ☐ Gestational Diabetes
- ☐ Heart Disease
- ☐ HIV/AIDS
- ☐ History of Chicken Pox
- ☐ Hypertension
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Psychiatric Illness
- ☐ Postpartum Depression
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ STD
- ☐ Uterine Problems
- ☐ MRSA

Additional History: _____

Past Obstetrical/Gynecological Surgeries:

SURGERY	YEAR	SURGERY	YEAR
D&C		Ovarian Surgery	
Hysteroscopy		L Ovarian cyst removal	
Infertility Surgery		R Ovarian cyst removal	
Tuboplasty		L Ovary removed	
Tubal Ligation		R Ovary removed	
Laparoscopy		Vaginal or bladder repair for prolapsed or incontinence	
Hysterectomy(vaginal)		Cesarean Section	
Hysterectomy(abdominal)		Uterine Ablation	
Myomectomy		Other (specify)	

List any additional surgeries you have had and date of the procedure (even minor procedures)

_____

_____

_____

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Patient Name: _____ Date of Birth: _____

Best number where you can be reached:

_____

_____

Please choose one……...

- ☐ **DO NOT** discuss any of my medical information with **ANYONE.**
- ☐ **I GIVE PERMISSION** to the office of Doctor's Eddington, Berault, Landry and Rosselot's staff to release any and all medical information to the following persons listed below.

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

_____ _____
Patients Signature Date

_____ _____
Office Staff Date

Jeanne F. Eddington, M.D
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FINANCIAL RESPONSIBILTIY FORM

Positive verification of your coverage cannot be made at this time. A current and true copy of your insurance card must be presented at the time of service or payment will be expected in full. You will receive services today with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for all the services rendered.

We will be happy to file your claim for you if we participate with your insurance plan. However, it should be understood that you are ultimately responsible for all services incurred as the contract for coverage is between you and your insurance carrier. Every policy is different and it is important for you to be aware of what your plan covers and what exclusions apply to you. If your policy refers to copay it will be collected at the time of service.

If an outstanding balance is not paid within 120 days of services rendered the balance would be forwarded to our collection agency and the policy holder and/or patient would be responsible for all collection and attorney fees.

I have read the above statement and understand what my financial responsibilities are for services rendered.

_____ _____

Patients Signature Date

_____ _____

Witness Signature Date

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PATIENT INFORMATION

Name listed on your insurance card:

_____
Last First Middle

Address: _____

_____
City State Zip

Social Security #: _____
Employer: _____
Employer Address: _____

_____
City State Zip

Date of Birth: _____
Cell Phone #: _____
Home Number: _____
Work Number: _____
Marital Status: _____
Occupation: _____

EMERGENCY CONTACT

Name: _____
Relationship to Patient: _____
Telephone: _____

POLICY HOLDER'S INFORMATION

(IF SAME AS ABOVE, LEAVE BOTTOM BLANK)

Name: _____
Last First Middle
Address: _____

_____
City State Zip

Social Security# _____
Employer: _____

Relationship to Patient: _____
Date of Birth: _____
Cell Number: _____
Occupation: _____

ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to myself or the named provider for professional services rendered.

Signed: _____ Date: _____
(Subscriber)

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process the claim.

Signed: _____ Date: _____
(Subscriber)