Mark A. Gapinski, MD, FACOG
25 N. Winfield Rd., Suite 511
Winfield, IL 60190
630-462-4963

Dear Patient,

Thank you for choosing Dr. Mark Gapinski's office for your gynecological care!

Please fill out the following forms as completely as possible. If you have any questions about these forms, please do not hesitate to contact our office.

To help assist our staff prepare for your first visit, please fax or mail your forms to our office prior to your appointment. If you have a copy of your insurance card, please include it as well.

Our secure office fax number is **630-462-0635**.

Our office address is **25 N. Winfield Rd., Suite 511, Winfield, IL 60190.**

If you are unable to send the forms to our office prior to your appointment, please contact us.

You may also want to plan to arrive early for your appointment to allow yourself some time to locate parking. There is open parking in parking Lot 1 and Lot 2 (the covered parking garage, east entrance), or free Valet Service in front of our building, the OutPatient Services Building, Entrance 1.

Please be sure to bring your insurance card and a photo ID with you to your first appointment. It will be necessary for our office to scan these cards into our computer system. If you do not have proof of insurance for your office visits, the charges will be your responsibility (see Billing Policy on page 6). Please also be prepared to pay any copayments for your visit.

If you have any questions regarding the office or these forms, please feel free to call our office. Our phone number is 630-462-4963.

Thank you, and we will see you at your first visit!

Alana Witt
Office Manager

PATIENT INFORMATION & HEALTH QUESTIONNAIRE

Patient Information:

Name: ____
Last First MI

Address: ____
Street Apt # City State Zip Code

Home: (_____) ______ - ________ Cell: (______) ______ - ________ Work: (_____) ______ -___ _____ x ______

At which number do you prefer to be reached? ☐ Home ☐ Cell ☐ Work

*E-mail address: ____(*This will be used for communication via our Patient Portal.)

Reason for Visit: ____
____

Primary Care Physician: ____

Who referred you to this office?

- ☐ I am a Previous Patient
- ☐ Primary Care Physician
- ☐ Other Physician ______________________________________
- ☐ Friend/Family ______________________________________
- ☐ Insurance Company
- ☐ Yellow Pages/Internet
- ☐ Other ____

Please provide us with your *pharmacy* information for future prescriptions.

Name ___________________________________

Street ___________________________________

City ___________________________________

Phone __________________________________

Date of Birth: ______/______/_______ Age: ________ Social Security Number: ______ - ____ - ________

Employer Name: ____ Occupation: __________________________________

Emergency Contact: Name: ______________________________________ Relation to yourself: _______________
Phone #: (______) _______-________

Spouse Information:

Name: ____ Date of Birth: ___/___/___

Social Security Number: ____-___-____ Employer ____

Insurance Information:

Name of Insurance Company: ____

Address: ____
(Provide address only if you do not have your card with you today, or if the address is not indicated on the card. Please have card available for the office to copy.)

Subscriber ID#: ____ Group/Case#:____________________________________

Policyholder: ____ Relationship to yourself: __________________________
(if you are not the policyholder)

Secondary Insurance:

Name of Insurance Company: ____

Address: ____

Subscriber ID#: ____ Group #: ______________________________________

Policyholder: ____ Relationship to yourself: __________________________
(if you are not the policyholder)

Please list all medications you are currently taking.

Name of Medication	Dosage and Frequency	When Started	Name of Prescribing Doctor

Personal Medical History:

Do you currently have, or have you ever, experienced any of the following?

YES	NO		YES	NO	
☐	☐	Asthma	☐	☐	Hypoglycemia
☐	☐	Cancer: type/location _______________	☐	☐	Thyroid Problems------if yes, ☐ hypothyroid
☐	☐	Chicken Pox	☐	☐	Kidney Problems ☐ hyperthyroid
☐	☐	Depression	☐	☐	Leakage of Urine ☐ thyroid nodule
☐	☐	Diabetes	☐	☐	Liver Problems
☐	☐	Emphysema	☐	☐	Ovarian Cysts requiring surgery
☐	☐	Uterine Fibroids	☐	☐	Rheumatic Fever
☐	☐	German Measles	☐	☐	Scarlet Fever
☐	☐	Hay Fever	☐	☐	Seizures
☐	☐	Migraines	☐	☐	Sinus Problems
☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	High Cholesterol	☐	☐	Ulcers
☐	☐	Hypertension (High Blood Pressure)	☐		Other - Please Specify _________________________

____

Allergies:

Drug Allergies: _____________________________________Reaction:_____________________________ ☐ None

Other Allergies: ____ ☐ Seasonal ☐ None

Surgical History:

List all past operations. ☐ None

Reason for Admission	Date	Procedure Performed	Doctor	Hospital

Hospital Admissions:

List those serious illnesses which required hospitalization. ☐ None

Reason for Admission	Date	Procedure Performed	Doctor	Hospital

Family Medical History:

Please indicate the following details regarding your family history:

Mother: ▢ Alive ▢ Deceased – Cause of Death ____________________

Father: ▢ Alive ▢ Deceased – Cause of Death ____________________

Siblings: ▢ Alive ▢ Deceased – Cause of Death ____________________

Maternal (Mother) Grandfather: ▢ Alive ▢ Deceased – Cause of Death ____________________

Maternal Grandmother: ▢ Alive ▢ Deceased – Cause of Death ____________________

Paternal (Father) Grandfather: ▢ Alive ▢ Deceased – Cause of Death ____________________

Paternal Grandmother: ▢ Alive ▢ Deceased – Cause of Death ____________________

Do your blood relatives have any of the following?

	YES	NO	Indicate Family Member's Relationship to You (i.e-"maternal aunt" or "paternal grandfather")
Cancer			Specify type of Cancer:
Diabetes			
Heart Disease			
Breast Disease			
High Blood Pressure			
High Cholesterol			
Blood Disorders			
Sickle Cell Disease			
Down's Syndrome			
Infants with Congenital Problems			

Social History:

Do you exercise? ▢ Yes ▢ No If yes, how many times per week? ____________________

Do you smoke? ▢ Yes ▢ No If yes, how many cigarettes per day? ____ How long have you been smoking? ___________

Have you smoked in the past? ▢ Yes ▢ No If yes, when did you quit? ____________________

Do you drink alcohol? ▢ Yes ▢ No ▢ Social If yes, how many drinks per week? ____________________

Do you drink caffeine? ▢ Yes ▢ No If yes, how many cups per day? ____________________

In the past 6 months, have you used: Cocaine? ▢ Yes ▢ No Heroin? ▢ Yes ▢ No

Have you *ever* injected recreational drugs? ▢ Yes ▢ No

Menstrual History:

Age at first period: ________ Date of last period (1st day): ________________

How many days does your period last? _________ How many days/weeks between your period? _________________

Do you have painful periods? ________ If so, please describe: ____________________

If you experience menstrual cramps, please describe whether mild, moderate, or severe: ____________________

Do you take any medication for cramps? _______ If so, please describe: ____________________

Do you bleed or spot between periods? _______ If so, please describe: ____________________

Do you have pain or experience bleeding during or after sexual activity? ______ If so, please describe: _______________

____

Gynecological History:

Please check if you *have, or have ever had* a history of:

- ▢ Herpes
- ▢ Trichomonas
- ▢ Chlamydia
- ▢ Gonorrhea
- ▢ Syphilis
- ▢ Genital warts (condyloma)

Current method of contraception: ______________________ If pills, please specify brand: __________________________

Date of your last pap smear: ____________ Test results: ____

Have you ever had an abnormal pap smear? ________ If yes, when? ____

What treatment did you receive? ____

Date of last mammogram: _______________ Test results: ____

Have you ever had an abnormal mammogram? _________ If yes, when? ____

What treatment did you receive? ____

Obstetrical History:

Do you have a history of infertility? ____________ If yes, please explain: ____

____

____

Specify Number of: Pregnancies ____________ Miscarriages ____________ Abortions ____________

	Pregnancy #1	Pregnancy #2	Pregnancy #3	Pregnancy #4	Pregnancy #5
Date of Delivery					
Vaginal/ C-Section					
Boy/Girl					
Baby's Weight					
Weeks Gestation **40 weeks is Full-Term**					
Complications?					
Pre-Term Labor?					
Epidural?					
Induction? Reason					
Doctor					
Hospital					

I affirm that the information given on these forms is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status.

Patient Initials _____________
Today's Date ______________

Billing Policy

- Payment is required at the time services are rendered. All copayments will be collected upon arrival to your appointment.
- If you are uninsured, or cannot provide proof of insurance at the time of service, a $150 initial payment will be required. Payment arrangements may be made for remaining balances, if necessary.
- Accounts over 30 days will incur a $10 rebilling fee.
- If your balance should fall past 90 days due, your account will be turned over to collections. Your account will be charged reasonable collection costs.
- There will be a $50 fee for returned checks.
- There is a $10 minimum for credit card payments.
- We appreciate timely payments on all balances incurred from our office, and payments may be made in our office or mailed in with the statement.

Assignment of Benefits

I hereby authorize direct payment of surgical/medical benefits to Dr. Mark Gapinski for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize Dr. Mark Gapinski to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Medicare/Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

PATIENT NAME (please print): ____

PARENT/GUARDIAN (please print): ______________________________________ Date: ______________

SIGNATURE: ____ Date: _____________