Francois M Blaudeau, MD, 3401 Independence Dr. Suite 221 Homewood, AL 35209

NAME: _____
LAST FIRST MIDDLE

ADDRESSS: _____

CITY: _____ AL: _____ ZIP: _____ E-MAIL: _____

AGE: _____ DATE OF BIRTH: _____ SS#: _____

HOME PHONE: _____ OTHER: _____ CELL: _____

E-Mail: _____

MARRIED / SINGLE / WIDOWED (Circle one) DL#: _____ STATE: _____

EMPLOYER: _____ WORK NUMBER: _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SPOUSE NAME: _____ DATE OF BIRTH: _____

SS#: _____ WORK NUMBER: _____

EMPLOYER: _____

RESPONSIBLE PARTY: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

ADDRESS: _____
(MEDICAL CLAIM ADDRESS)
PHONE NUMBER: _____ POLICY HOLDER: _____

CONTRACT NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE: _____

ADDRESS: _____
(MEDICAL CLAIM ADDRESS)
PHONE NUMBER: _____ POLICY HOLDER: _____

CONTRACT NUMBER: _____ GROUP NUMBER: _____

EMERGENCY INFORMATION-OTHER THAN SPOUSE

NAME: _____ PHONE NUMBER: _____

REFFERRED BY: _____ PRIMARY CARE M.D.: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM FOR PAYMENT. I HEREBY ASSIGN TO THE OFFICE ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAN THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED UNDER MY INSURANCE POLICY. I UNDERSTAND THAT T AM RESPONSIBLE FOR ANY COLLECTION FEES INCURRED DUE TO DELINQUENCY OF MY ACCOUNT WITH DR. FRANCOIS M. BLAUDEAU.

CONSENT TO TREATMENT: I, OR WE, THE UNDERSIGNED, DO HEREBY AUTHORIZE FRANCOIS M. BLAUDEAU M.D. TO PROVIDE WHATEVER TREATMENT HE DEEMS NECESSARY IN THE TREATMENT OF, _____. I, OR WE, FURTHER AUTHORIZE, DR. BLAUDEAU TO DELEGATE SUCH DUTIES AS HE DEEMS NECESSARY TO OTHER PHYSICAINS. IT IS FURTHER UNDERSTOOD THAT SHOULD DR. BLAUDEAU BE UNAVAILABLE AT THE TIME TREATMENT IS NECESSAY, THEN DR. BLAUDEAU MAY DIRECT A PHYSICAIN OF HIS CHOOSING TO PROVIDE TREATMENT.

_____ _____
SIGNATURE **DATE**

FRANCOIS BLAUDEAU, M.D. , J.D.

NAME_____
AGE____DOB_____WEIGHT_____HEIGHT_____
ALLERGIES_____
CURRENT MEDICATIONS

_____

_____

TOBACCO USAGE **Y or N** CIGARETTE _____ PACKS PER DAY
ALCOHOLC BEVERAGE **Y or N** HOW MANY DRINKS PER WEEK_____
CURRENT OR PAST DRUG USAGE **Y OR N**

LIST ALL PREGNANCIES
YEAR WT SEX VAGINAL/CSECTION WEEKS GESTATION COMPLICATIONS

_____
_____
_____
_____
_____
_____
_____

LIST NUMBER OF
ABORTIONS ____ MISCARRIAGES____

LIST ALL SURGERY (WHAT AND WHEN)

_____

_____

_____

MENSTRUAL CYCLE
DATE OF LAST PERIOD_____
YOUR AGE AT ONSET_____
DO YOU HAVE A CYCLE EVERY MONTH Y OR N
USUAL DURATION _____ DAYS
FLOW IS LIGHT MEDIUM HEAVY (CIRCLE)
PAIN OR CRAMPS Y OR N

ABNORMAL PAP SMEARS
Y OR N
HOW MANY ABNORMAL_____
DID YOU HAVE A BIOPSY_____
DID YOU HAVE A LEEP_____

PERSONAL MEDICAL HISTORY (CIRCLE)

ANEMIA HEART DISEASE DIABETIC DEPRESSION MIGRANES

HIGH BLOOD PRESSURE CANCER STROKE MENTAL ILLNESS

OTHER_____

_____

FAMILY HISTORY
HAS YOUR MOTHER, SISTERS, AUNTS, OR GRANDMOTHER (MATERNAL SIDE) EVER HAD

ANY FEMALE CANCER (BREAST, CERVICAL, OVARIAN, UTERINE)? **Y OR N**

PLEASE LIST TYPE OF CANCER AND YOUR RELATIONSHIP (EXAMPLE- MOTHER- BREAST CANCER)

_____