



270 East Town St  
Columbus, OH 43215  
614-224-0115  
fax 614-224-0776

Dr. Mark S. Brown, Dr. Tamara Thompson, Dr. Kelly Hoskins Tyler and staff are pleased that you have chosen this practice and welcome you to ***Midtown Obstetrics & Gynecology, Inc.***

We are located at 270 East Town Street. Our goal is to provide you with high quality, personalized health care, with an emphasis on patient education. You will have access to a wide range of patient education videos and reading material.

We have included a ***Patient Registration Form***, a ***Medical Release Form***, and a ***Medical History Form*** to make registration as easy as possible. You may bring them already filled out to your appointment, or return all forms by mail, provided there is enough time before your scheduled appointment. We also have available our ***Practice Brochure***, that highlights the services we offer as well as financial and practice policies. Please ask for one at your appointment. We strongly encourage you to take a few minutes and read our practice brochure. Please note the map and directions to the office. Please remember to bring your **insurance card**, **picture ID** and your **copay** (if applicable) with you to your visit. You must have these required items for your appointment or we will be happy to reschedule after you receive them.

In order to serve you better we have allowed more time for your first visit. We require at least 24 hours notice if you are not able to make your appointment. Please call between the hours of **8:30am** to **4:30pm** for any scheduling change. A “**new patient no show**” fee of **\$35.00** will be charged if you do not cancel your appointment at least 24 hours prior to the scheduled visit.

We look forward to establishing a mutually positive relationship with you by providing the best of women’s health care.

Sincerely,

Mark S. Brown, M.D. FACOG  
Tamara Thompson, M.D. FACOG  
Kelly Hoskins Tyler, M.D. FACOG



**Mark S. Brown, M.D., FACOG**  
**Tamara Thompson, M.D. FACOG**  
**Kelly Hoskins Tyler, M.D. FACOG**  
**Midtown Obstetrics & Gynecology, Inc.**  
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(614) 224-0115 Fax (614) 224-0776

**MEDICAL INFORMATION RELEASE**

I hereby request and authorize: \_\_\_\_\_  
(previous Doctor's Name)

\_\_\_\_\_  
(previous Doctor's Address)

\_\_\_\_\_

\_\_\_\_\_

Previous Doctors' Phone: (\_\_\_\_\_) \_\_\_\_\_

Previous Doctors' Fax: (\_\_\_\_\_) \_\_\_\_\_

to disclose any and ALL records and reports pertaining to my diagnosis, care and treatment of related obstetrical and gynecological care or related condition for the past five(5) years to:

**Midtown Obstetrics & Gynecology, Inc.**  
270 East Town Street  
Columbus, OH 43215

Name: \_\_\_\_\_ Date \_\_\_\_\_

Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

\*\*Would your previous records be under another name? (ex. Maiden Name)

Previous name: \_\_\_\_\_

Thank you for your prompt response.

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For office use only:

Records needed?  yes  no

MIDTOWN OBSTETRICS & GYNECOLOGY  
**REGISTRATION**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Social Security Number \_\_\_\_\_ email \_\_\_\_\_

Address \_\_\_\_\_ Race \_\_\_\_\_

\_\_\_\_\_ Hispanic? Y or N

Phone: Home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

Patient Employer \_\_\_\_\_

Subscriber/Spouse/Guardian Social Security Number \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

Referring Physician \_\_\_\_\_ Family Physician \_\_\_\_\_

In case of emergency, please list the name and phone number of a friend or relative not living at your address:

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

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I hereby authorize, Midtown Obstetrics & Gynecology, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all medical benefits, to include Medicare, private, and other health plans. I understand that I am responsible for the full amount of my bill regardless of insurance coverage. I have been advised that selected insurance companies may not cover the charges for medical services conveyed to me or those for whom I am responsible. I hereby acknowledge that I am fully liable for any costs associated with medical services rendered to me by Midtown Obstetrics & Gynecology, Inc. I hereby promise to personally pay those costs promptly as requested. I understand that any overpayment will be refunded directly to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signed \_\_\_\_\_ Date \_\_\_\_\_

How did you hear about Midtown Obstetrics & Gynecology, Inc? (CIRCLE ONE)  
Friend Physician Established patient yellow pages online other \_\_\_\_\_

List any medications you are now taking. please include over the counter medications and supplements.

Are you allergic to any medications?  Yes  No  
If yes, list medications to which you are allergic, and the reactions.

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**FAMILY HISTORY:** For each member below, follow the line across the page and mark an X in those boxes which indicate: their present state of health, (good) (poor), or their death (write in cause), and any of the illnesses that they have ever had. Print the names of your relatives living or dead in the spaces below.

	Age	Health			Cause of death	Allergies or Asthma	Sickle Cell Anemia	Bleeding Tendencies	Diabetes	Breast Cancer	Epilepsy	Ovarian Cancer	Osteoporosis	High Blood Pressure	Kidney or Bladder Problems	Mental Illness	Alcohol Abuse	Drug Abuse	Heart Problems	Lung Problems	Birth Defects	Blood Clots
		Good	Poor	Deceased																		
Father:																						
Mother:																						
Brothers or Sisters:																						
Spouse:																						
Children:																						
Grandparents (Mark an X for Illness only.)																						

**Major Hospitalizations:** If you have ever been hospitalized for any serious medical illness or operation, write in you most recent hospitalizations below. Check this box  if you have had more than three such hospitalizations. Do not include normal pregnancies.

	Year	Operation or Illness	Name of Hospital	City and State
1st hospitalization				
2nd hospitalization				
3rd hospitalization				
4th hospitalization				

In your own words, briefly describe why you have an appointment today.

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# Midtown Obstetrics & Gynecology

## IDENTIFICATION DATA

Fill in the following information. PLEASE PRINT.

Social Security Number \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_ Blood Type (if known) \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  Married  Separated  Divorced  Widowed  Single

Home Telephone (Area Code \_\_\_\_\_) \_\_\_\_\_ Education: \_\_\_\_\_ years Elementary \_\_\_\_\_ years High School

Business Telephone (Area Code \_\_\_\_\_) \_\_\_\_\_ \_\_\_\_\_ years College, Technical, Business, etc.

Cell Phone \_\_\_\_\_ Fax No. \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Race \_\_\_\_\_ Hispanic/Latin Y N

Husband/ Partner Name \_\_\_\_\_ Age \_\_\_\_\_ Address (if different from yours) \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_ Occupation \_\_\_\_\_

## YOUR HEALTH HISTORY: Mark an X in the box next to any of the following illnesses you have ever had.

<input type="checkbox"/> anemia	<input type="checkbox"/> diabetes	<input type="checkbox"/> hernia	<input type="checkbox"/> mononucleosis	<input type="checkbox"/> stroke
<input type="checkbox"/> arthritis	<input type="checkbox"/> diverticulosis	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> mumps	<input type="checkbox"/> thyroid disease
<input type="checkbox"/> asthma	<input type="checkbox"/> emphysema	<input type="checkbox"/> high cholesterol	<input type="checkbox"/> pneumonia	<input type="checkbox"/> transfusions
<input type="checkbox"/> bronchitis	<input type="checkbox"/> epilepsy	<input type="checkbox"/> hives or rashes	<input type="checkbox"/> rheumatic fever	<input type="checkbox"/> urinary tract infections
<input type="checkbox"/> cancer	<input type="checkbox"/> German measles	<input type="checkbox"/> infertility	<input type="checkbox"/> scarlet fever	<input type="checkbox"/> other: _____
<input type="checkbox"/> chicken pox	<input type="checkbox"/> heart disease	<input type="checkbox"/> liver disease	<input type="checkbox"/> sexually transmitted diseases	<input type="checkbox"/> _____
<input type="checkbox"/> depression	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> measles	kind: _____	<input type="checkbox"/> _____

Do you currently smoke?  Yes  No If yes, how much? \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever smoked?  Yes  No Quit? how long ago? \_\_\_\_\_

Do you use alcohol?  Yes  No If yes, how much? \_\_\_\_\_

Do you use any street drugs?  Yes  No If yes, how much? \_\_\_\_\_

## REPRODUCTIVE HISTORY

Last menstrual period: \_\_\_\_\_ Last mammogram: \_\_\_\_\_ Last Pap smear: \_\_\_\_\_

Have you ever had an abnormal Pap?  Yes  No Was last Pap normal?  Yes  No

Menstrual Period: Age of onset: \_\_\_\_\_ years old How many days between periods? \_\_\_\_\_ How many days do you flow? \_\_\_\_\_

Circle any of these you have with or before flows: Cramps Bloating Mood changes Clots

## Summary of Past Pregnancies Including Miscarriages and Abortions:

DATE OF DELIVERY	PLACE OF DELIVERY	DURATION OF PREG.	DURATION OF LABOR	VAGINAL OR CESAREAN DEL.	BABY'S NAME	SEX	WEIGHT	PROBLEMS WITH PREGNANCY, LABOR, DELIVERY OR BABY

## Contraceptive History: Please identify specific names of IUD's, birth control pills, etc. Please list contraceptives in order of use.

TYPE OF CONTRACEPTION	DURATION OF USAGE		REASON FOR DISCONTINUING USAGE
	FROM	TO	

Do you douche? (circle one): No Regularly Occasionally What do you douche with? \_\_\_\_\_

Do you perform your own breast exams? (circle one): No Monthly Occasionally Have you ever been shown how to examine your breasts?  Yes  No