Institute for Women's Health and Body

New Patient Registration Form

Date: _____ Patient Name: _____ DOB: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

SS#: _____ Drivers License #: _____

Marital Status: _____ Spouse Name: _____ Contact Phone: _____

Emergency Contact: _____Phone:_____

Employer: _____ Occupation: _____ Business Phone: _____

Pharmacy: _____ Location: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Who is financially responsible for this bill? _____ Relationship to you: _____

Address if different then your own: _____ Phone: _____

Insurance Company (Primary): _____ Insurance Company (Secondary): _____

How did you hear about us? ( ) Internet ( ) Insurance Company

( ) Friend/Family: _____ ( ) Doctor: _____

Gender: Female **Preferred Language**: _____

ASSIGNMENT OF INSURANCE

I hereby authorize the payment of benefits of my insurance policy, if any, to be paid directly to The Institute for Women's Health and Body for the services rendered by any of its employees.

I further authorize the release of any medical information required by my insurance company.

I understand that I am financially responsible for charges not paid by my insurance company. I also agree to be responsible for any charges incurred in the collection of this account, should I default from payment. Such charges include, but are not limited to, legal fees, collection fees or late charges.

I certify that the above information is true and correct to the best of my knowledge.

Signature_____ Date_____

Institute for Women's Health and Body
Health History Form

Name_____ **Date**_____

Age_____ **Place of birth**_____

Reason for today's visit_____

Date of last Pap smear_____ **Mammogram**_____ **Colonoscopy**_____ **Bone Density**_____

Other current medical problems_____

All surgeries (& age) _____

Other illnesses/fractures/hospitalizations_____

Medications (& doses) _____

_____

Vitamins and herbal supplements_____

ALLERGIES to drugs (and type of reaction)_____

PREGNANCIES INCLUDING BIRTHS/MISCARRIAGES/ABORTIONS/ECTOPICS

DATE OF PREGNANCY	SEX (M) (F)	VAGINAL, CESAREAN, OR OTHER OUTCOME	BIRTH WEIGHT	# OF WEEKS PREGNANT	COMMENTS/COMPLICATIONS OF DELIVERY

PAST GYN HISTORY:

First day of last menstrual period_____ Periods are light___ medium___ heavy__

Period occurs every ____days, and last for _____days Age of 1st period_____

Have you ever had an abnormal Pap smear and when? _____

Are you sexually active? _____ **Optional**: Heterosexual_____Homosexual_____Bisexual_____

Do you use birth control/type_____ History of sexually transmitted disease _____

FAMILY HISTORY:

Mother or sister with history of breast cancer_____ Ovarian cancer_____ Colon cancer_____

Other immediate family medical history_____

SOCIAL HISTORY:

Do you smoke/amount_____ Drink alcohol/amount_____ Drug use_____

Occupation: _____ Type of exercise/frequency_____ Are you stressed?_____

Have you ever been physically or sexually abused/age: _____

REVIEW OF SYSTEMS: Do you have:

___Vaginal or Uterine Prolapse
___Urine leakage Urgency or Frequency
___Vaginal Dryness
___Pain or Discomfort with intercourse
___Depression
___Mental Illness
___Asthma
___Osteopenia or Osteoporosis
___ Cancer history
___ Menopausal symptoms
___ Muscle/joint pain

___Chest pain/heart disease
___Shortness of breath
___HIV/AIDS
___Eye problems
___High blood pressure
___Stomach/intestinal problems
___Blood in stool
___Hearing problems
___Unusual cough
___ Pelvic pain
___ Eating disorder

___Bleeding or Blood clotting disorder
___Cervical or Vaginal Cancer
___Have had five or more sexual partners in your life
___Have history of a sexually transmitted disease
___Began having sexual intercourse before the age of 16
___Have not had a pap test within the last seven years

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Notice regarding preventive care visit

Most health insurances provide benefits for preventive care (also called annual visit, well woman visit, or yearly). A preventive care exam includes an age specific evaluation and examination and may include the collection of a Pap smear. This visit also includes issues specific for your age group that are not extensive.

If you are having a problem that needs immediate attention, please notify us at the time of your arrival. You may need to be scheduled for your preventive care visit for another day as appointments are scheduled based on the nature of the visit. If it is not an urgent problem, you can choose to have your preventive visit now and come back another time for a consultation so that we can evaluate your problem in a thorough and comprehensive manner.

If you are a Medicare patient, Medicare helps pay for a preventive breast/pelvic exam every 2 years. For high risk women, Medicare may help pay for a Pap test once every year. Be sure to talk to your doctor/nurse practitioner to find out how often you need these tests. Medicare requires you to pay for any other uncovered services.

_____	_____	_____
Printed Patient Name	Patient Signature	Date