

**A WOMAN'S PLACE**  
**PATIENT REGISTRATION FORM**

**Patient Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell or Pager No. \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Marital Status \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone No./Address: \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone No/Address: (if physician) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Other Addresses (seasonal) \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone No. : \_\_\_\_\_ Religion (optional): \_\_\_\_\_

**Responsible Party/Guardian:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Telephone No.: Home \_\_\_\_\_ Work \_\_\_\_\_

Cell Phone No.: \_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_ Relationship to Patient: \_\_\_\_\_

**Spouse Information:**

Spouse: \_\_\_\_\_ Employer: \_\_\_\_\_ Work/Cell/Pager: \_\_\_\_\_

**Primary Insurance Information:**

Company Name: \_\_\_\_\_ Group No.: \_\_\_\_\_ ID No.: \_\_\_\_\_

Primary Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Effective Date of Insurance: \_\_\_\_\_ Insurance Phone No. \_\_\_\_\_

Deductible: \_\_\_\_\_ Co-pay \_\_\_\_\_ Other Information: \_\_\_\_\_

**Secondary Insurance Information:**

Company Name: \_\_\_\_\_ Group No.: \_\_\_\_\_ ID No.: \_\_\_\_\_

Primary Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Effective Date of Insurance: \_\_\_\_\_ Insurance Phone No. \_\_\_\_\_

Deductible: \_\_\_\_\_ Co-pay \_\_\_\_\_ Other Information: \_\_\_\_\_

**I consent to/and authorize treatment for the above named patient. I authorize the release of any information requested by health professionals participating in my care.**

**Signed (patient, parent or legal guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_**

**A WOMAN'S PLACE  
FINANCIAL & PRIVACY POLICIES**

Thank you for choosing us as your health care provider. We are committed to providing quality medical care. In order to reduce potential confusion and misunderstandings, we have adopted the following Policies and require you to read and sign it prior to the commencement of any treatment.

**INSURANCE**

Your insurance policy is a contract between you and your insurance plan. We cannot bill your insurance company unless you give us current and valid insurance information. As a courtesy, we will file claims for those plans with which we have an agreement. If your insurance company does not pay within a reasonable amount of time, we will look to you for payment. All health plans are not the same, and they do not always cover the same services. In the event your health plan determines a service is "not covered", you will be responsible for the complete charge. This office is not responsible for disputing insurance company decisions regarding coverage. Payment is due upon receipt of a statement from our office. We expect that you know your insurance benefits including, but not limited to: deductible and co-payment amounts as well as labs, radiology facilities and hospitals contracted with your plan. It is your responsibility to notify our office when your insurance plan or benefits change. Any costs incurred by this office because of incorrect information provided to us by you will be your responsibility.

If you have insurance coverage with a plan with which we do not participate or you have no health insurance plan, our charges for your care and treatment are due at the time of service. We reserve the right to bill for after-hours gynecology phone consultations. Insurance plans in general do not pay for these after-hours services.

**DEDUCTIBLES/COPAY**

Our insurance contracts require us to collect deductibles and co-pays at the time of service.

**MINORS.** A parent or legal guardian must accompany a minor patient on his or her first visit to our office so we can obtain a signature to treat the minor patient. A minor may be treated on subsequent visits without a parent or guardian if we have written permission from the parent or legal guardian. The adult accompanying the minor patient is responsible for payment of the services at the time of service.

**PATIENT PRIVACY.** Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's *Notice of Privacy Practices* in the reception area. You are not required to read this *Notice*. However we would like your acknowledgement that you have been notified that the practice has such a *Notice of Privacy Practices*.

**APPOINTMENTS.** We strive to provide the best possible service and availability to all of our patients. Our policy is to charge for missed appointments unless cancelled at least 24 hours in advance. Please help us serve you better by keeping your scheduled appointments or by calling as early as possible to cancel.

I hereby authorize A Woman's Place to release any information to my insurance company for payment of my medical charges, or to review activities related to my health care provider's participation with my health plan. I assign to A Woman's Place any and all benefits to which the patient or insured party is entitled for medical services rendered.

**I have read the above Policies. I understand and agree to the Financial and Privacy Policies.**

X

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

# PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

## Review of Systems

Within the last 6 months have you had any problems related to the following systems?

Circle Yes or No

<b>Constitutional Symptoms</b>	<b>(Comments)</b>	<b>Musculoskeletal</b>	<b>(Comments)</b>
Weight change	Y N	Bone pain	Y N
Chills / Fever	Y N	Muscle pain	Y N
Sleep Disorder	Y N	Joint pain	Y N
<b>Eyes</b>		<b>Integumentary (Skin)</b>	
Double vision	Y N	Rash	Y N
Glaucoma	Y N	Lumps or bumps	Y N
Cataracts	Y N	Moles, skin tags	Y N
<b>Ears / Nose / Throat / Mouth</b>		<b>Respiratory</b>	
Hearing changes	Y N	Wheezing	Y N
Sore throat	Y N	Frequent cough	Y N
Sinus problem	Y N	Shortness of breath	Y N
<b>Cardiovascular</b>		<b>Neurological</b>	
Chest pain	Y N	Tremors	Y N
Irregular heartbeat	Y N	Dizzy spells	Y N
Swelling in ankles	Y N	Numbness / tingling	Y N
<b>Psychologic</b>		<b>Gastrointestinal</b>	
Are you generally happy?	Y N	Abdominal pain	Y N
Do you feel depressed?	Y N	Nausea/vomiting	Y N
Do you feel anxious?	Y N	Indigestion/heartburn	Y N
Do you feel safe in your home?	Y N	Constipation/Diarrhea	Y N
		Other:	
<b>Endocrine</b>		<b>Genitourinary</b>	
Excessive thirst	Y N	Urinary incontinence (loss of urine)	Y N
Too hot/cold	Y N	• Spontaneous	Y N
Tired/fatigued	Y N	• With activity, cough or laugh	Y N
Irregular periods	Y N	Urinary frequency >8 times/day	Y N
Heavy bleeding	Y N	Painful urination	Y N
Bleeding after menopause	Y N	Vaginal discharge	Y N
		Genital itching, pain, burning	Y N
<b>Hematologic/Lymphatic</b>		<b>Sexual History</b>	
Swollen glands	Y N	Have you ever been sexually active?	Y N
Blood clotting problem	Y N	Are you currently sexually active?	
Bruising	Y N	(husband/partner)	Y N
		Sexually active with: male female both	
<b>Allergic/Immunologic</b>		Method of contraception _____	
Hay fever	Y N	Change in sex drive	Y N
Drug allergies	Y N	Painful intercourse	Y N
Food	Y N	Sexual trauma	Y N
Other			
<b>Breast</b>		Patient's Signature _____	
Nipple discharge	Y N	Physician's Signature _____	
Pain	Y N	Date _____	
Lump	Y N		

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

### Medical History

<b>Your Medical Problems</b> <input type="checkbox"/> None ( <i>High Blood Pressure, Diabetes, Cancer, Asthma, etc.</i> ) _____ _____ _____ _____	<b>Pregnancy History</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Year</td> <td style="width: 30%;">M/F</td> <td style="width: 40%;">Vaginal or C-section?</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	Year	M/F	Vaginal or C-section?	_____	_____	_____	_____	_____	_____	_____	_____	_____
Year	M/F	Vaginal or C-section?											
_____	_____	_____											
_____	_____	_____											
_____	_____	_____											

<b>Surgeries</b> <input type="checkbox"/> None	<b>Year or Age</b>	<b>Other Surgeries</b>	<b>Year or Age</b>	<b>GYN / Breast / Colon History</b>
Tubal ligation <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____	_____	Last Pap: _____
D&C <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____	_____	Last Mammo: _____
Leep/Cone of Cervix <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____	_____	Last Colonoscopy: _____
Hysterectomy <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____	_____	Any abnormal PAPs? _____
Tonsillectomy <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____	_____	Regular periods? _____
Appendectomy <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____	_____	Length of periods: _____
_____	_____	_____	_____	Age at 1st period: _____
_____	_____	_____	_____	Age at menopause _____
_____	_____	_____	_____	Hormone replacement _____

**Allergies** to medications?  None (*If yes, please explain type of reaction, i.e., hives, wheezing, upset stomach, swelling, etc.*)  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>Current prescription medicines</b> <input type="checkbox"/> None <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name of Drug</th> <th style="width: 15%;">mg dose</th> <th style="width: 15%;"># tablets</th> <th style="width: 15%;"># times per day</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>	Name of Drug	mg dose	# tablets	# times per day	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	<b>Over the counter medicines</b> ( <i>Aspirin, Tylenol, Ibuprofen, Aleve, vitamins &amp; herbals.</i> ) _____ _____ _____ _____ _____
Name of Drug	mg dose	# tablets	# times per day																						
_____	_____	_____	_____																						
_____	_____	_____	_____																						
_____	_____	_____	_____																						
_____	_____	_____	_____																						
_____	_____	_____	_____																						

### Family History

	Living	Deceased	Illness	Cause of Death / Age
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister (s)	<input type="checkbox"/> # _____	<input type="checkbox"/> # _____	_____	_____
Brother (s)	<input type="checkbox"/> # _____	<input type="checkbox"/> # _____	_____	_____

<b>Other Family History:</b>	Y	N	Family Member	Yes	No	Family Member
1. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Cancer (type)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Gynecologic	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Social History

Smoke?  Yes  No If yes, # packs per day: \_\_\_\_\_ # of years: \_\_\_\_\_ If quit, when? \_\_\_\_\_  
 Alcohol?  Yes  No If yes, how many drinks per week? \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Coffee - how much \_\_\_\_\_  Tea - how much \_\_\_\_\_  Soda - how much \_\_\_\_\_  
 Have you ever used recreational drugs? (i.e., marijuana, cocaine) If yes, what/when: \_\_\_\_\_  
 Domestic Violence: \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_