PATIENT REGISTRATION FORMS

Name: _____ Date of Birth: _____

Address: _____ Cell#: _____

City: _____ Home#: _____

State: _____ Zip Code: _____ SSN #: _____

Email: _____

Marital Status: ☐ S ☐ M ☐ D ☐ W

Employment status: ☐ Full Time ☐ Part Time ☐ Student ☐ Unemployed ☐ Retired Emergency

Name: _____ Cell#: _____

Relationship: _____

Insurance Subscriber Information:

Name: _____ Date of Birth: _____

Relationship: _____ Social Security#: _____

Primary Care Physician:

Name: _____ Office#: _____

Address: _____

Race (Check all that apply):

☐ American Indian ☐ Asian ☐ African ☐ American ☐ Nat Hawaiian/Pacific ☐ Islander, Caucasian Unknown, Other _____ ☐ Declined

Ethnicity (Check all that apply):

☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ Declined

Communication Preferences (Check all that apply):

☐ Mail ☐ Phone Call ☐ Text Message ☐ MyChart ☐ Declined

PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully. We are required by law to maintain the privacy of protected health information, give you notice of our legal duties and privacy practices regarding your health information and to follow the terms of the notice currently in effect. We may use and disclose your health information for your treatment and to provide you with treatment related health care services. We may use and disclose your health information so that others may bill and receive payment for you, an insurance company or a third party for the treatment and services you received.

Signature: _____ **Date:** _____

PATIENT HISTORY

Name: _____

DOB: _____

Medication allergies: _____

Are you allergic t o any of the following? ☐ **Latex** ☐ **Iodine**

PLEASE CHECK THE BOX IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS:

☐ **Anemia**	☐ **Asthma**	☐ **Stroke**	☐ **Thyroid Problems**
☐ **Depression**	☐ **Anxiety**	☐ **Arthritis**	☐ **Seizures**
☐ **Venereal Disease**	☐ **Bowel Trouble**	☐ **Heart murmur**	☐ **Pneumonia**
☐ **Mental Illness**	☐ **Hypertension**	☐ **Heart Problems**	☐ **Blood Clots**
☐ **Kidney Problems**	☐ **Diabetes**	☐ **Migraines**	☐ **Osteoporosis**
☐ **Kidney Stones**	☐ **Fibroids**	☐ **Ovarian Cyst**	☐ **Endometriosis**

Cancer: _____

	DATE	WHERE	RESULTS
PAP SMEAR			
MAMMOGRAM			
BONE DENSITY SCAN			
COLONOSCOPY			

At what age did menstruation begin? _ _ _ _

What was the first day of your last menstrual p e r i o d ? _ _ _ _

If you are in menopause, at what age did you start? _ _ _ _

Do you perform self-breast exams? ☐ **Yes** ☐ **No** **If yes, how often?** ____

Are you currently sexually active? ☐ **Yes** ☐ **No**

What do you currently use for birth control? _____

PLEASE CHECK IF YOU HAVE HAD ANY OF ,THE FOLLOWING SURGERIES:

- ☐ Bladder Surgery
- ☐ Breast Surgery/Mastectomy
- ☐ Tubal Ligation
- ☐ Other: _ _ _ _ _ _ _ _ _ _ _ _

- ☐ Appendectomy
- ☐ Caesarean Section
- ☐ Hysterectomy

- ☐ Thyroidectomy
- ☐ Ovarian Cyst Removal
- ☐ Gallbladder

- ☐ BSO
- ☐ D&C
- ☐ LEEP

OB/GYN HISTORY

	NUMBER
BIRTHS	
MISCARRIAGES	
TERMINATIONS	
LIVING CHILDREN	

FAMILY HISTORY

ILLNESS	RELATIVE (with age of onset)
DIABETES	
STROKE	
HYPERTENSION	
DRINKING PROBLEM	
BREAST CANCER	
OVARIAN CANCER	
COLON CANCER	

SOCIAL HISTORY:

Tobacco use: ☐ Past/Date quit: __ ☐ Present- packs per day: ___ ☐ Never

Alcohol use: ☐ Never ☐ Occasionally Regular use - drinks per day: ___

Drug use: ☐ Past ☐ Present - type:_____ ☐ Never

MEDICATION LIST (with dosage):

Authorization and Responsibility Agreement

We invite you to discuss with us any questions regarding our services or policies. The best health services are based on a friendly, mutual understanding between provider and patient.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.

I hereby authorize my insurance company to pay directly to Women's Health and Menopause Center any professional or medical expense benefits for services rendered. If my insurance company does not pay my balance in full within 30 days, I will be responsible for contacting my carrier to inquire about the delay.

I authorize Women's Health and Menopause Center to release any information pertinent to my case to any insurance company, adjuster, and attorney involved in the case, and hereby release Women's Health and Menopause from any consequence thereof. A photocopy of this assignment shall be considered as effective and valid as the original.

I understand it is my responsibility to inform this office of any changes in my medical insurance status.

_____ _____

Signature of patient or responsible person *Date*

Financial Responsibility

Our office policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager, or current and complete insurance information is submitted. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 60 days past due, a $15 late fee will be added to the balance owed. If an account is turned over to our collection agency a 50% fee will be added to the account to cover the agency fees.

Women's Health and Menopause does not participate with any Non-MCO Medicaid plan (manage care) also known as "straight" Medicaid. Women's Health and Menopause Center also does not accept any Medicaid plans as secondary or tertiary insurances. If you have a MCO (managed care) or straight Medicaid, you will be responsible for all deductibles, co-insurances and co-pays from your primary insurance.

Returned checks will be accessed a $15 fee each time it is declined by the bank. We will put an NSF check through twice. {If payment on a collection account is returned it will be accessed a 50% fee. _____ Initials

_____ _____

Signature of patient or responsible person *Date*