



Patient Registration Form

TODAY'S DATE: _____

PATIENT INFORMATION	INSURANCE INFORMATION
Last Name: _____ MI: _____ First Name: _____ Social Security #: _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Date of Birth: _____ Email: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age: _____ <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for ____ years Occupation: _____ Patient Employer/School: _____ Employer/School Address: _____ Employer/School Phone #: _____ Spouse's Name: _____ Spouse's DOB: _____ Social Security # _____ Spouse's Employer: _____	Who is Responsible for this account? _____ Relationship to Patient: _____ Primary Insurance Co: _____ Policy #: _____ Group # _____ Subscriber's Name: _____ Date of Birth: _____ SS# _____ Relationship to Patient: _____ Is patient covered by additional insurance? <input type="checkbox"/> yes <input type="checkbox"/> no Secondary Insurance Co: _____ Policy #: _____ Group #: _____ Subscriber's Name: _____ Subscriber's DOB: _____ SS#: _____
INSURANCE ASSIGNMENT AND RELEASE	
I certify that I have insurance coverage with <div style="text-align: center;"><u>Name of Insurance Company(ies):</u> _____</div> and assign directly to: Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.	
MEDICARE/MEDIGAP AUTHORIZATION	
I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made to me or on my behalf to: <div style="text-align: center;">Name of Doctor or Clinic: _____</div> for any services furnished to me by that provider. <div style="text-align: center;">*****</div> To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap Insurer and their agents any information needed to determine these benefits or benefits for related services.	
Signature of Beneficiary, Guardian, or Personal Representative	
<i>Sign below</i>	
Signature: _____ Date: _____	
Please print name below of Beneficiary, Guardian or Personal Representative	
Printed Name: _____ Relationship: _____	
PATIENT'S PHONE NUMBERS	
Home () _____ Cell () _____ Work () _____ Alternate # () _____	
In case of Emergency, Contact -	
Name: _____	
Relationship: _____ Home () _____	
Cell () _____ Work () _____	



New Patient History Form

Patient's Name: _____

DOB: _____

Current Medical Problems **What is the reason for your visit?**

Allergies: _____

What medical problems do you currently have?

Current Medications (prescription & over-the-counter):

Past Medical History

Please check if you have ever had any of the following (explain any 'yes' responses)

Serious Illnesses: yes no _____

Hospitalizations: yes no _____

Operations: yes no _____

Psychiatric Care: yes no _____

Ever been tested for HIV? yes no if yes, when? _____

Vaccination History (please indicate date of last administration):

Tetanus _____

Measles, Mumps, Rubella _____

Have you ever had chicken pox yes no Varicella Vaccine date: _____

Hepatitis B series _____

Gardasil (cervical cancer vaccine) _____

Pneumonia _____

Zostavax (shingles vaccine) _____

Social History

With whom do you live? _____

Occupation: _____

Do you smoke? now previously never How much? _____ How long? _____

Do you drink alcohol? none occasional 1-2 daily 3-5 daily

Family History:

(list siblings)	Age	Good	Poor	Deceased	Illnesses
Father		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mother		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Do you or have you had any of the following:

Problem	Yes	No	Problem	Yes	No	Problem	Yes	No
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Teary, watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal pain	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Ear problems	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Mouth problems	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Black stools	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Excess stress	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Pain urinating	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Positive TB skin test	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>

Please explain the problems cited above:

Date of last menstrual period: _____

Have you had a mammogram? yes no

Date of last Pap Smear: _____

Are you pregnant? yes no

Number of children:

How did you hear about Comprehensive Women's Health?

Friend

Newspaper ad

Internet search

Other _____

I affirm that the information included in this history form is true to the best of my knowledge:

Patient Signature: _____

Date: _____

History Reviewed By: _____

Date: _____