

Premier Women's Health

Please complete the following:

Today's Date: _____

Name _____ Age _____ Marital Status _____

Address: _____

Phone (Home) _____ Phone (work) _____ Phone (Cell) _____

Date of Birth _____ Social Security Number _____

Occupation _____ Employer _____

Responsible Party (if minor) _____ Relationship _____

Spouse's name _____ Date of Birth _____ Social Security Number _____

Spouse's Employer _____ Spouse's work phone _____

Emergency Contact and Phone Number: _____

Who referred you to our practice? _____

What is the name and phone number of your primary care physician?

INSURANCE INFORMATION

Do you have medical insurance? _____ Yes _____ No

(If yes, the receptionist will make a copy of your card(s).)

Patient Release of Information

The best phone number to reach you Monday through Friday, 8 AM to 5 PM is:

(_ _ _) _ _ _ - _ _ _ _ (ext. _____ - if applicable).

If you cannot be reached, do we have your permission to leave a message or results

with: (check all that apply) My parent: _____ My spouse: _____ No, only me _____

Home answering machine: _____ Work, Voice Mail: (_ _ _) _ _ _ - _ _ _ _ Ext. _____

I hereby authorize the office of Premier Women's Health to release any medical information required in the course of examination and treatment and permit payment directly to them any benefits due for services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. I authorize this office to use "FAX" as a means of rapid communication with other physician's offices, pharmacies, laboratories and insurance companies that are pertinent to my care. I understand that this office follows HIPAA protocols and protects my privacy as a patient. By signing this form, I am consenting to medical treatment.

I have read and understand the above statements.

Date: _____ Signature: _____

Briefly state your reason for coming to the doctor: _____

OBSTETRICAL HISTORY:

No. of pregnancies: _____

No. of vaginal deliveries _____

No. of C-sections _____

No. of miscarriages _____

No. of other pregnancies _____

GYNECOLOGICAL HISTORY:

Date Last menstrual period: _____

Age at first menstrual period: _____

Menstrual flow occurs every _____ days

Menstrual flow lasts _____ days

Date of last pap test _____

Birth control method _____

Please list any medical problems that you have had (e.g. hypertension, diabetes, thyroid disease, etc)

Please list any surgeries you have had:

Please list current medications including vitamins and herbal supplements:

Are you allergic to any medications? Please list: _____

Do you smoke? _____ How much per day? _____

Do you drink alcohol? _____ If so how much? _____

FAMILY HISTORY: Please check if family members have any of the following:

	Mother	Father	Grand-parents	Siblings	Aunt/ Uncle	Children
Breast Cancer						
Ovarian Cancer						
Uterine Cancer						
Colon Cancer						
Other Cancer						
Hypertension						
Heart Disease						
Clots/Embolism						
Diabetes						