New Patient Registration – Innovative Women's Healthcare Solutions, Inc.

Please Print

Today's Date:

PATIENT INFORMATION

Full Legal Name: (First) (Middle) (Last)				Name Normally Used: (Nickname)	
Address: (Number) (Street) (Apt. No.)				Email:	
City:	State:	Zip:	Social Security Number:	Home Phone:	
Date of Birth:	Age:	Sex:	Marital Status:	Occupation:	
Employer Name:	Street Address:		City:	State:	Zip:
Business Phone: (Including Ext.)			Patients Driver's License No.:		State:
Other Physicians You See					
How Did You Hear About Us?					

SPOUSE INFORMATION

Full Legal Name: (First) (Middle) (Last)		Occupation:		
Address: (If Diff. From Above)	City:	State:	Zip:	Home Phone:
Employer Address:	City:	State:	Zip:	Business Phone: (Ext)

INSURANCE INFORMATION

Primary Insurance Company Name:	Group No.:	ID/Certificate No.:
Subscriber Name:	Address To Mail Claims:	
Secondary Insurance Company Name:	Group No.:	ID/Certificate No.:
Subscriber Name:		

EMERGENCY INFORMATION

Person To Notify In Case Of Emergency		Relationship:	
Address: (Number) (Street)		(Apt. No.)	
City:	State:	Zip:	Home Phone:

INFORMATION FOR THE PATIENT

1. Patients who are self-pay or have nonstandard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. Payment is expected at the time services are rendered from the patient or guarantor.

2. Patients with contract health plans should present their insurance ID cards to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc.) require a copayment or co-insurance that will be collected at the time of service.

3. If you have any questions we will be happy to assist you.

SIGNATURE:

Innovative Women's Healthcare Solutions, Inc.

Name_____ Age_____ Date_____

Physician you are seeing today: _____

Physicians you have seen in the past:

_____

_____

REASON FOR TODAY'S VISIT:

_____

_____

CURRENT MEDICAL PROBLEMS:

_____

_____

List all CURRENT PRESCRIPTION MEDICINES (include dosage, reason you take it, who prescribed it):

_____

_____

List all OVER-THE-COUNTER MEDICINES, vitamins, and food supplements that you take:

_____

_____

ALLERGIES: SENSITIVITIES:

_____

_____

List SURGERIES you have had (include year, surgeon, hospital)

_____

_____

Describe HOSPITALIZATIONS ILLNESSES not included above (include year, hospital)

_____

_____

_____

Age of first period _____ Date of last normal period _____ No. of pregnancies _____

Age of first period _____ Date of last normal period _____ No. of pregnancies _____

No. of live births _____ No. of children living _____

Birth control method _____ Date of last pap _____

Done Where _____

Date of last mammogram _____

Do you have now or any history of (circle)

Irregular periods Bad menstrual cramps Heavy periods Pelvic pain Infertility

Female trouble Hot flashes Vaginal dryness Vaginal discharge

Vaginal odor Vaginal itching Abnormal Pap Smear Breast problems

Abnormal mammogram PMS

Who in your family has/had (circle if cause of death and write age of death):

Heart disease _____

Genetic disorder _____

Diabetes _____

Cancer _____

Thyroid Disease _____

Alcoholism _____

Mental Illness _____

Arthritis _____

Glaucoma _____

Asthma _____

Tuberculosis _____

Hypertension _____

Who lives in your household? _____

Where do/did you work? _____

How much do you weigh? _____ How much would you like to weigh? _____ Heaviest Weight? _____

Do /did you EXERCISE? _____ How much? _____ hrs/wk No. of years_____

Year you quit? _____

Do/did you SMOKE? _____ How Much? _____ packs/day No. of years_____

Year you quit? _____

Do/did you drink ALCOHOL? _____ How Much? _____ drinks/week No. of years _____

Year you quit? _____

Previous or current problem with alcohol? _____

AA? _____

Do/did you use (circle): Caffeine NutraSweet Marijuana Cocaine

Chewing tobacco Diet pills

Please Sign: _____ Date_____