Woman to Woman
Obstetrics and Gynecology Associates

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Board Certified Physician

REGISTRATION FORM

PATIENT INFORMATION

Date:

Last Name: First Name: Middle:

Address:

City: State: Zip Code:

Home Phone: ( ) Work Phone: ( )

Cellular Phone: Email Address:

SSN: ___ ___ ___-___ ___-___ ___ ___ ___ Date of Birth: Age:

Status: □ Single □ Married □ Widowed □ Divorced

Occupation:

Employer:

Emergency Contact Person: Phone: ( )

INSURANCE INFORMATION

(If insurance information is incorrect or incomplete, the patient will be responsible for bill)

Primary Insurance Company Name:

Phone: ( )

Address: City/State: Zip Code

Subscriber Name: Employer:

SSN: ___ ___ ___-___ ___-___ ___ ___ ___ Date of Birth:

Relationship to Patient

ID# Group #

SECONDARY INSURANCE INFORMATION

(If insurance information is incorrect or incomplete, the patient will be responsible for bill)

Secondary Insurance Company Name:

Phone: ( )

Address: City/State: Zip Code:

Subscriber Name: Employer:

SSN: ___ ___ ___-___ ___-___ ___ ___ ___ Date of Birth:

Relationship to Patient

ID# Group #

GUARANTOR INFORMATION

(Patients 18 and under)

Last Name: First Name: Middle:

Address: City: State: Zip Code:

Home Phone: ( ) Work Phone: ( )

SSN: ___ ___ ___-___ ___-___ ___ ___ ___ Date of Birth:

Occupation:

Employer:

Consent/Release/Authorization

The insurance information listed on page one is current and correct. If any information is incorrect I understand I will be held responsible for any unpaid balance. It is my responsibility to give any change in insurance information to Woman to Woman Obstetrical and Gynecological Associates, LLC.

I authorize Woman to Woman Obstetrical and Gynecological Associates, LLC to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I authorize Woman to Woman Obstetrical and Gynecological Associates, LLC to disclose my health information for treatment, payment and health care operations.
I have read and understand the above and hereby voluntarily give my consent and authorization.

Patient Signature_____ Date: ___/___/___

PERSONAL AND FAMILY HISTORY (Place "X" in box for those that apply)										
Disease	You	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brothers	Sisters	Children
Alcoholism										
Anemia										
Arthritis										
Asthma										
Cancer										
Colon Polyps										
Diabetes										
Epilepsy										
Glaucoma										
Heart Disease										
High Cholesterol										
Hypertension										
Kidney Disease										
Kidney Stones										
Mental Illness										
NT Defect										
Spina Bifida										
Osteoporosis										
Sickle Cell										
Stomach Ulcers										
Stroke										
Thyroid Disease										
Tuberculosis										
Inherited Disease										
Still living	X									
Deceased at Age	___									

PRIOR MEDICAL / SURGICAL / OBSTETRICAL HISTORY

Please list all significant prior medical illnesses and current problems for which your are under medical treatment

Please list all significant prior surgical procedures and the year that they were performed:

Year	Procedure

Please list all pregnancies you have had, including miscarriages and ectopic pregnancies:

Year	Mode of Delivery	Gestational Age	Sex	Weight	Comments

Gynecological history
Last menstrual period:
Forms of contraception:
Last Pap Smear:
□ Yes □ No Onset of sexual history under 16 years of age
□ Yes □ No Five of more sexual partners in a lifetime
□ Yes □ No History of sexually transmitted disease
If Yes, □ Gonorrhea □ Herpes □Chlamydia □Genital Warts/HPV □Hepatitis B □Hepatitis C □Syphilis □PID
□ Yes □ No History of HIV
□ Yes □ No Fewer than 3 negative Pap smears within previous 7 years
□ Yes □ No Exposed to DES in utero
□Yes □No Do you desire pregnancy at this time?
□Yes □No Are you currently sexually active?
□Yes □No Do you examine your breasts every month?
□Yes □No Do you have pain after intercourse?
□Yes □No Do you have bleeding after intercourse?

Social History
Do you use tobacco? Have you in the past? How many per day?
Do you use alcoholic beverages? □Yes □No Weekly amount?
Do you use drugs? □Yes □No If so, which ones?
Have you ever had an unwanted sexual encounter? □Yes □No Have you ever been hit or abused in a relationship? □Yes □No
Do you feel unsafe in your current relationship? □Yes □No
Do you exercise? □Yes □No

Present symptoms		
General/Constitutional	□Weight loss □Weight gain □Fever □Night Sweats	□No Complaints
Eyes	□Double vision □Tearing □Blind spots □Eye pain	□No Complaints
Ears/Nose/Throat//Mouth	□Headaches □Dizziness □Lightheadedness □Nose bleeding □Nasal obstruction	□No Complaints
Ears/Nose/Throat/Mouth	□Dental difficulties □Bleeding gums □Neck stiffness □Neck pain □Neck tenderness	□No Complaints
Respiratory	□Wheezing □Cough □Coughing Blood □Respiratory infection □Tubercolosis	□No Complaints
Gastrointestinal	□Poor Appetite □Difficulty Swallowing □Indigestion □Abdominal pain □Heartburn □Nausea	□No Complaints
Gastrointestinal	□Vomiting □Yellow skin □Constipation □Diarrhea □Abdominal Stools □Hemorrhoids	□No Complaints
Musculoskeletal	□Joint Pain □Limitation of Motion □Muscular Weakness □Muscle Cramps	□No Complaints
Skin/Breast	□Rash □Itching □Pigmentation □Changes in hair growth or loss □Nail changes □Breast Lumps	□No Complaints
Skin/Breast	□Breast Tenderness □Breast Swelling □Nipple Discharge □Fibrocystic Disease	□No Complaints
Neurological	□Convulsions □Paralysis □Tremor □Difficulties with Speech or Memory	□No Complaints
Neurological	□Sensor or Motor Disturbances □Problem with Muscular Coordination	□No Complaints
Psychiatric	□Nervousness □Emotional Problems □Anxiety □Depression □Previous Psychiatric Care	□No Complaints
Endocrine	□Increased Water Intake □Hormone Therapy □Abnormal Growth □Intolerance to Cold or Heat	□No Complaints
Hematology/Lymphatic	□Anemia □Bleeding Tendency □Previous Transfusions and Reactions □Rh Incompatibility	□No Complaints
Allergic/Immunologic	□Reactions to Drugs □Reaction to Food □Reaction to Insects □ Problems with Anesthesia	□No Complaints
Cardiovascular	□Chest Pain □Irregular Heart Beat □Fainting □Shortness of Breadth with Exertion □Swelling	□No Complaints
Cardiovascular	□Heart Murmur □Phlebitis □Painful Extremity with Movement □Varicosities	□No Complaints
Other Complaints		