Women's Health Care of Warren, PA

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Name (Printed) _____ Date of Birth_____ Age_____
Reason for today's visit: **Annual Exam** or **Other** If other, specify reason _____

_____

Date of last menstrual period _____

This form is divided into two sections. In the first section, we would like you to provide us with an update of your medical history. The second section provides information about patient rights and insurance coverage. Please read the attached document package and provide your acknowledgment of the information by signing below. Thank you.

SECTION 1
Patient Interval History

1. Have you had any menstrual problems since your last visit? _____
   _____
2. Have you had a hysterectomy? _____
3. Have you had any recent surgeries? What type? _____
4. Do you have any allergies? _____
5. Are you currently on any medications? Please list. _____
   _____
   _____
6. Is there any family illness/history (whom?) that we should know about? _____
   _____

SECTION 2
Patient Rights and Insurance Coverage

- ❑ I have read and understand the **Office Policy Changes**. In particular, I have read the **In-Office/Lab Procedure Policy** and **the Pre-certification Policy**. My signature below indicates that **I AGREE** to have any necessary procedure that I have consented to. It also indicates that **I AGREE** to pay for any charges that my insurance may not cover.

- ❑ I have read and understand the **Consent to Use or Disclose Protected Health Information.**

- ❑ I have read and understand the **Notice of Privacy Practices Acknowledgment.** I am giving you my permission to leave messages on my voice mail/answering machine regarding my medical care.

_____ _____
Patient Signature Date

Women's Health Care of Warren

It is the patient's responsibility to provide all information requested. If any information is omitted or illegible, the patient will be billed directly and, will have to submit their claim to their insurance company.

Date:	Student: Yes No	Primary Care Physician's Name:
Patient's Name:		Primary Care Physician's Address: Phone Number:
Date of Birth:	Social Security Number:	Who will be responsible for payment: **Self / Parent / Other:_____**

Patient Information

Home Address (Street):	Home Phone Number (including Area Code):
City: State: Zip Code:	E-mail Address:
Occupation:	Cell Phone Number (including Area Code): Carrier

Employment Information

Employed by:	City: State: Zip Code
Employer's Street Address:	Business Phone Number:

Primary Insurance Information			Secondary Insurance Information **(If different from Primary)**		
Name of insurance company:			Name of insurance company:		
Insurance Company Street Address:			Insurance Company Street Address:		
City	State	Zip	City	State	Zip
Subscriber ID #	Relationship to Patient		Subscriber ID #	Relationship to Patient	
Group #	Group Name		Group #	Group Name	
Name of primary policy holder:			Name of primary policy holder:		
Policy holder's date of birth:	Social Security Number:		Policy holder's date of birth:	Social Security Number:	

In order to submit a claim for payment, we must have your authorization to release medical information to your insurance carrier.

* I hereby authorize Women's Health Care of Warren, PA to furnish information to insurance carriers concerning my illness and treatment.
* I also request payment of government benefits either to myself or to the party who accepts assignment below. I authorize payment of all medical benefits to Women's Health Care of Warren, PA for all medical services.
* I understand that some medical services may not be a covered benefit under my insurance policy (e.g. routine exams) and that I am financially responsible for all medical services not covered under my insurance contract.

Contact person in case of an emergency:	Telephone number:	Relationship to patient:

X _____ X _____

Signature (denotes acceptance for all of the above) **Date**

New Credit Card Policy

I give Women's Health Care permission to bill the credit card I have left on file for any balance I have incurred which is 30 days or more past due. I understand that by giving this authorization, I will not incur any bill handling or late fees.

_____ _____

Credit Card Number **Type of Card** **Expiration Date & Code**

New Cancellation Policy

As of October 1, 2004, any patient who does not cancel their visit and fails to show up will be billed a $50 fee.

Women's Health Care of Warren

65 Mountain Blvd. Ext., Warren NJ 07059
(732)469-9400

Confidential Health Inventory

Date:

Patient's Name: Date of Birth: Age:

How did you hear about our practice? Please circle one and include name.

Friend/ Family Member/ Physician/ Other

Personal History

Present Weight_____ 1 Year Ago_____ Highest Weight_____ When_____ Height_____

MENSTRUAL HISTORY

Age at onset_____
Regular ___ Yes ___No
Cycle_____Days (from start to start)
Usual Duration _____Days
Flow ___Light ___Med. ___Heavy
Pains or Cramps ___ Yes ___ No
Date of Last Period _____
Method of Contraception_____

List Pregnancies (Includes Miscarriages/ Abortions)						
Year	**Weight**	**Sex**	**Hrs. in Labor**	**Anesthesia**	**Complications**	

HAVE YOU EVER HAD SURGERY OR ACCIDENTAL INJURY?

Type	Year	Where	Doctor's Name
1.			
2.			
3.			

Have You Ever Had: Hypertension_____ Cancer _____
Diabetes _____ Heart Disease_____

Other Significant Illness (Specify)_____

Are you currently seeing another doctor?_____ Why?_____

Have you recently undergone any medical testing? If so, what type of testing?_____

_____

Please List All Medications You Are Currently Taking:_____

_____

_____

Reason for Today's visit:_____

_____

Signature _____ Date:_____

Provider's Signature _____ Date:_____

HAVE YOU EVER HAD MEDICATION ALLERGIES: YES NO IF YES, PLEASE LIST:

TRANSFUSIONS? YES NO IF YES, WHEN:
HAVE YOU HAD A MAMMOGRAM? YES NO IF YES, WHEN:
DO YOU SMOKE? YES NO IF YES, HOW MUCH:
DO YOU DRINK ALCOHOL? YES NO IF YES, HOW OFTEN:
DO YOU CURRENTLY USE DRUGS? YES NO IF YES, WHAT:
HAVE YOU EVER USED DRUGS? YES NO IF YES, WHEN:
MARITAL STATUS: SINGLE MARRIED SEPERATED DIVORCED WIDOWED
YOUR OCCUPATION:

FAMILY HISTORY	LIVING		DECEASED		Has any close relative had:			
	Age	**Health**	**Age**	**Health at death**		**YES**	**NO**	**WHO**
Father					Cancer:			
Mother					Tuberculosis			
of Siblings/Names					Diabetes			
					Heart Problems			
					High Blood Pressure			
					Stroke			
					Epilespy			
of Children/ Names					Suicide			
					Mental illness			
					Hysterectomy			
					Cesarean section:			
					Kidney Trouble			

DID YOU HAVE SIGNIFICANT TROUBLE WITH ANY OF THE FOLLOWING CONDITIONS? (CHECK ALL THAT APPLY)

	Headaches		Swelling of Hands or Feet		Joint Pain
	Sore Throat		Diarrhea		Nose Bleeds
	Spitting Up Blood		Frequent or Painful Urination		Swollen Glands
	Chest Pain		Blood in Urine		Sinus Trouble
	Shortness of Breath		Blood Bowel Movements		Nausea
	Difficulty Walking		Blurred or Double Vision		Vomiting
	Cough		Hearing Disorder		Stiff Neck
	Constipation		Dental Problems		

ANY OTHER CONDITIONS THAT WERE NOT COVERED ABOVE: