ISLAND WOMEN'S CARE

REGISTRATION FORM

(Please Print)

Today's date:

PCP:
Office Location:

PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.

Marital status (circle one)
Single / Mar / Div / Sep / Wid

Pregnant or Nursing: ❑ Yes ❑ No

Ethnicity: Race: Birth date: / / Age: Sex: ❑ M ❑ F

Street address: Social Security no.: Home phone no.: ( )
Cell Phone no: ( )

P.O. box: City: State: ZIP Code:

Employment Status: ☐ Employed ☐ Unemployed ☐ Full/Part Time Student ☐ Retired

Occupation: Employer: Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work

CONSENT TO TEXT (For appointment reminders) YES NO

EMAIL ADDRESS:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: / / Address (if different): Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation: Employer: Employer address: Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Medicare ❑ BCBS ❑ Aetna ❑ Cigna ❑ Tricare
❑ Other

Subscriber's name: Subscriber's S.S. no.: Birth date: / / Policy No: Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): Subscriber's name: DOB: Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Is this an accident? ☐ Yes ☐ No Date of Injury: Is this a motor vehicle accident? YES or NO

Drivers License # State Issued:

IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Island Women's Care or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

ISLAND WOMEN'S CARE, LLC

NEW PATIENT MEDICAL HISTORY FORM

Date:___/___/___

Printed Patient Name:____

Date of Birth:____________ Age:______ Primary Care Physician:____________________

Do you have a previous OB/GYN physician? ☐Yes ☐No If yes, who?____________________

Why are you leaving your physician? ☐Second Opinion ☐Other____________________

Age of your first period?___Date last menstrual period began___/___/___How long did it last?________
Flow of periods are: normal___heavier___lighter___ Are your periods regular?_____ How often?_______
Do you have pain with periods?__Does pain require medication?___If so, what medication__________
How many past pregnancies?_______# of deliveries_______Any miscarriages?________
# of Vaginal Deliveries__________ # of C-sections___________
Present type of birth control used______________________

Date of last pap smear/result?__________ Date of last mammogram?____________
Date of last colonoscopy?_____________ Date of last bone density?____________

MEDICATION LIST

Please bring all of your current medication bottles with you to your first appointment

Medication	Dose	Times Per Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Allergies/Side Effects

Medication Allergy	Reaction/Side Effects

PAST MEDICAL HISTORY

Medical Condition	Date of Onset	Treating Physician	Details
Abnormal Pap			
Abnormal Periods			
Anxiety			
Bartholins Cysts			
Breast Infections			
Cancer			
Depression			
Diabetes			
Digestive Problems			
Endometriosis			
Fainting/Syncope			
Fibrocystic Breasts			
Hearing Impaired			Hearing Aid ☐ Yes ☐ No
Heart Problems			
High Blood Pressure			
High Cholesterol			
Ovarian Cysts			
Pelvic Organ Prolapse			
STD's			
Stress Urinary Incont.			
Stroke			
Thyroid Disease			
Uterine Fibroids			

Other Past Medical History:____

____

____

____

PAST SURGICAL HISTORY

Operation	Date	Details

Have you had a hysterectomy? YES or NO **Do you have your ovaries? YES or NO**

Do you have your cervix? YES or NO

FAMILY HISTORY

Breast Cancer ☐ Yes ☐ No If yes, what relationship?______________________________ Deceased? Y or N

Ovarian Cancer ☐Yes ☐No If yes, what relationship?______________________________ Deceased? Y or N

Uterine Cancer ☐Yes ☐No If yes, what relationship?______________________________ Deceased? Y or N

Colon Cancer ☐Yes ☐No If yes, what relationship?______________________________ Deceased? Y or N

Other terminal illness:_____________________ relationship?__________________________ Deceased? Y or N

SOCIAL HISTORY

Primary Language: ☐English ☐Spanish ☐______________________ Translator Needed? ☐Yes ☐No

Do you Smoke? ☐Yes ☐No ☐Former Smoker
Age of onset_______ Packs per day?_____ # of years_____ What year did you quit?______

Marital Status:________________________ Sexually Active________________________

Date of last Pneumonia vaccine________________________ Date of Last Influenza vaccine__________________
Date of Last Covid Vaccine____________________________

Alcohol Use/Controlled Substances:

Type	Amount	Frequency	Quit

What is the name of your pharmacy?___________________________ City?______________________________

Pharmacy phone number?_____________________________

Printed Name of Patient____

Signature of Patient/Guardian____

PATIENTS UNDER AGE 16:
Father/Guardian Name_____________________________ Mother/Guardian Name___________________________

ISLAND WOMEN'S CARE, LLC

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my individually identifiable health information(protected health information or PHI) and medical information by *Island Women's Care, LLC* in order to carry out treatment, payment or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this consent form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to releasing information to me in the following manner(s):

VIA EMAIL **PLEASE INITIAL**

OK to email me ____________

VIA MAIL

OK to mail to home address ____________

VIA HOME TELEPHONE

OK to leave a detailed message ____________

Leave call back number ONLY ____________

VIA CELL PHONE

OK to leave detailed message ____________

Leave call back number ONLY ____________

The following persons may speak to *Island Women's Care, LLC* regarding my health information:

______________________________ **Relationship** ______________________________

______________________________ **Relationship** ______________________________

______________________________ **Relationship** ______________________________

BY SIGNING BELOW, I ATTEST THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE

Printed Name of Patient: ______________________________________

Signature of Insured/Guardian: ______________________________ **Date:** ________

ISLAND WOMEN'S CARE, LLC

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INFORMED AUTHORIZATION AND CONSENT FOR THE RELEASE OF MEDICAL RECORDS

I hereby authorize *ISLAND WOMEN'S CARE, LLC* to release and/or obtain medical records for:

_______________________________________ DOB: _______________
(PRINT VERY CLEARLY PATIENT'S NAME)

( ) RELEASE TO

____

____

____

( ) OBTAIN FROM

____

____

____

FOR THE PURPOSE OF CONTINUITY OF CARE

INFORMATION TO BE DISCLOSED:

( ) Medical Notes/Summary ( ) Operative/Procedure Reports ( ) Annual visit

( ) PAP/HPV Type ( ) Mammogram Report ( ) Pelvic U/S ( ) Bone Density

( ) Recent Labs ( ) Pathology ( ) Last 2 years of documentation ( ) _______________

I UNDERSTAND THAT THESE MEDICAL RECORDS MAY OR MAY NOT CONTAIN INFORMATION PERTAINING TO PSYCHIATRIC COUNSELING OR TESTING, ALCOHOL OR DRUG ABUSE COUNSELING OR TESTING, AND/OR HIV/ARC TESTING. I DO EXPRESSLY AND VOLUNTARILY AUTHORIZE THE DISCLOSURE OF THE SAID MEDICAL RECORDS TO THE PERSON(S) AND/OR ENTITIES AS STATED ABOVE. I UNDERSTAND THAT INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE PRIVACY LAWS. THIS AUTHORIZATION/CONSENT WILL REMAIN IN EFFECT FOR A PERIOD OF ONE YEAR FROM THE DATE OF SERVICE STATED BELOW, UNLESS OTHERWISE REVOKED IN WRITING BY THE PERSON TO WHICH IT PERTAINS.

_______________________________________ DATE: _______________
(SIGNATURE OF PATIENT, PARENT, LEGAL GUARDIAN OR LEGALLY AUTHORIZED AGENT)