Patient Registration Form

Personal Information

Today's Date _____ Social Security _____ Birthday _____
Name _____
Address _____
City/State/Zip _____
Age _____ ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed
Employer _____ Date of Employment _____
Employer Address _____
Referred By _____ Primary Physician _____

Telephone Information

Home Phone _____ Work Phone _____
E-mail _____ Cell Phone _____
When is the best time to reach you? __ Mon ___ Tue ___ Wed ___ Thurs ___ Fri AM/PM
Where do you prefer to receive calls? ___ Home ___ Work ___ Cell Phone
Emergency Contact _____ Relationship _____
Home Phone _____ Work Phone _____
Cell Phone _____

Insurance Information

Primary Insurance _____ Member ID# _____
Insured Name _____ DOB _____
Insured SS# _____ Insured Employer _____
Claims Address & Phone # _____

I authorize Janet B. Goff and Jessica P. Brown of Juniper Women's Health & Wellness to release any information acquired in the course of my medical examination and treatment to my insurance company, third party payers, case utilization, managed care review companies, and Health Care Financing Administration. I further authorize the release of this information to all other TPWC agencies or affiliated institutions or individuals who will be providing healthcare or social services to me.

_____

Print Name Patient Signature

PATIENT HISTORY FORM

Name : _____ Date: _____

Date of Birth: _____ Age: _____ SSN: _____

Family Physician: _____ Referring Physician: _____

Status: _____ Single _____ Married _____Divorced _____ Widow _____ Separated

Race: ___ Am Indian/Alaskan Native ___ Asian ___ Black/African American ___ White
___ Native Hawaiian/Other Pacific Islander ___ Unknown/Decline

Ethnicity: ___ African ___ Arab ___ Ashkenazi Jew ___ Aus. Aborigine ___ Chinese ___ German ___ Indian
___ Hispanic or Latino ___ Iranian ___ Japanese ___ Mediterranean ___ Not Hispanic or Latino
___ Scandinavian ___ Sephardic Jew ___ Slavic ___ Slovak ___ Unknown/Decline

Language: ___ English ___ Spanish; Castilian

What is the main reason you are here today? _____

Do you have any of the following medical conditions? (circle all that apply)

Asthma	Heart Problems	Coronary Artery Disease	Blood clotts	Diabetes
High Blood Pressure	Arthritis	Heart Attack	Stroke	Diverticulitis
High Cholesterol	Interstitial Cystitis	Liver Disease/Hepatitis	Atrial Fibrillation	Depression/Anxiety
Irritable Bowels	Bladder infections	Low/High thyroid	Fibromyalgia	Gastric Reflux

Please list any other medical conditions you have: _____
_____

Please list any medications or supplements you are taking:

Medication/Supplement Name Dosage How often Reason for taking

_____
_____
_____

Are you allergic to any medications or foods: Please list:

Medication/Food Reaction

_____
_____

Have you had any surgeries? Please list:

Surgery Date Reason for surgery

_____
_____
_____

Do any of the following problems run in your family? (circle all that apply) If yes, who?

Diabetes	Heart Disease	High Cholesterol	Uterine Cancer	Colon Cancer
Osteoporosis	Stroke	Hemophilla/Bleeding	Ovarian Cancer	Breast Cancer
High Blood Pressure	Blood Clots			

_____

_____

What is relationship status? (circle one) Married / Single / Widowed / Divorced / Live-in Partner
Do you smoke or use tobacco? Yes/No _____ packs/day
Do you drink alcohol? Yes/No How much? _____
Do you use any illegal drugs or drugs that are not prescribed for you? Yes/No
In the last 6 months, has anyone hit you, kicked you, slapped you, or forced you to have sex? Yes/No
Do you feel safe at home? Yes/No

GYN History

Have you had a hysterectomy? Yes/No Reason? _____
If yes, do you have your ovaries? No/ Yes, I have both ovaries/ Not sure/ I have one (right or left)
When was the first day of your last menstrual period? _____
How often do you have periods? _____ Are they regular? _____
How long do your periods last? _____ days
Are your periods heavy or painful? _____
Do you bleed in between periods? Yes/No
Have you had any sexually transmitted infections? Yes/No _____
When was your last pap smear? _____ Have you had any abnormal pap smears? Yes/No
Do you use birth control? Yes/No If yes, please circle one:

Tubal Pills Patches IUD Nuva Ring Implanon Condoms Withdrawal
Natural Family Planning/Rhythm Method

OB History: Please list all of your pregnancies (including any miscarriages or abortions)

Born	How far along?	Weight	Vaginal or C-section	Problems?

_____

_____

_____

Are you having any of the following symptoms, today or very recently? (circle all that apply)

Fever/Chills	Nausea/Vomiting		Diarrhea	Constipation	Blood in stool
Chest pain	Palpitations	Coughing	Wheezing	Shortness of Breath	Swelling in feet
Congestion	Sinus Pain	Pelvic pain	Abdominal Pain	Vaginal Discharge	Rectal bleeding
Body sores/ulcers	Acne	Rash	Excess Hair growth		
Pain with urinating	Leaking urine	Urinary urgency		Urinary Frequency	
Weight gain	Weight loss	Fainting	Fatigue	Muscle/Joint pain	Easy bruising/bleeding

ACKNOWLEDGEMENT OF RECEIPT

OF PRIVACY PRACTICE NOTICE

I have been presented with a copy of the notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under Federal and State law and outlining my rights regarding my health information and treatment.

PRINT NAME: _____

SIGNATURE: _____**DATE:** _____

I GIVE PERMISSION TO DISCLOSE INFORMATION IN REGARDS TO MY HEALTH RECORD TO THE FOLLOWING PERSONS:

_____

Please be advised that if you list no one, we are unable to release ANY information regarding your health record.

We may also call you by name in the waiting area when you physician is ready to see you. We may also disclose your protected information, as necessary, to contact you to remind you of your appointment.

INTERNAL USE ONLY:

If patient refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

PRESENTED ON (date and time): _____

BY (name and title): _____