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
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

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:** _____

Caroline Millan, MD, FACOG

Carolyn Eskridge, MD, FACOG
38 Blackgum Rd, Suite D
Pawleys Island, SC 29585
PH: 843-235-1222 Fax: 843-314-4020

ISLAND WOMEN'S CARE, LLC

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)

ISLAND WOMEN'S CARE

Office Policies and Procedures/Consent to Treat Form

Receipt Acknowledgment Form

By signing below, I acknowledge that I have received, reviewed, and understand and will comply with policies and procedures explained in the Island Women's Care LLC Policies and Procedures form. In addition, I am asking for medical care and treatment at this facility and agree to accept services which may diagnose a medical condition, procedures to treat my condition and routine medical care including in-house labs and vaccination. I also acknowledge that if sent to an outside facility for any type of imaging services, lab work, or any other type of medical treatment and or services that I am responsible for verifying with insurance cost and coverage with the outside facility. Island Women's Care does not handle billing for outside facilities.

X _____

PRINT NAME

X _____

SIGNATURE

DATE _____

REVISED 06.10.2025

Island Women's Care, LLC

NO SHOW POLICY

Island Women's Care, LLC schedules appointments so that each patient receives the appropriate time to be seen by our physicians. It is very important that you keep scheduled appointments. Island Women's Care, LLC sends reminder text messages and emails prior to appointments.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and to accommodate those patients who are waiting to schedule an appointment with our physicians. As a courtesy to our office as well as to those patients who are waiting, we will need a 24-hour notice.

If you do not cancel or reschedule your appointment within at least a 24-hour period, we may assess a $35.00 "NO SHOW" service charge to your account. This "NO SHOW" charge is not reimbursed by your insurance company. It will be billed directly to you.

I UNDERSTAND THE "NO SHOW" POLICY OF ISLAND WOMEN'S CARE, LLC AND I UNDERSTAND THAT I MUST CANCEL OR RESCHEDULE ANY APPOINTMENT AT LEAST 24 HOURS IN ADVANCE IN ORDER TO AVOID A POTENTIAL NO SHOW CHARGE.

DATE: _____

PATIENTS NAME (PRINT): _____

DOB: _____

PATIENTS SIGNATURE: _____