PATIENT REGISTRATION

Primary Care Doctor:

Preferred pharmacy:

Doctor who referred you to us:

Reason for visit:

NAME (last, first mi)		SEX	AGE	DATE OF BIRTH		MARITAL STATUS	
MAILING ADDRESS			SOCIAL SECURITY#			DRIVER'S LICENSE#	
CITY	STATE	ZIP	CIRCLE ALL THAT APPLY:	EMPLOYEE	RETIRED	DISABLED	STUDENT
EMAIL ADDRESS			EMPLOYER/SCHOOL			OCCUPATION	
PRIMARY PHONE		WORK PHONE					

SPOUSE/GUARDIAN INFORMATION

NAME (last, first mi)		RELATION TO PATIENT	SOCIAL SECURITY#	DATE OF BIRTH
ADDRESS		OCCUPATION		
CITY	STATE	ZIP	EMPLOYER	
PRIMARY PHONE		WORK PHONE		

EMERGENCY CONTACT - REQUIRED (IF DIFFFERENT THAN THE PERSON LISTED ABOVE, PLEASE ADD INFO.)		
NAME	RELATIONSHIP	PHONE #

INSURANCE

PRIMARY	SECONDARY

** PLEASE PRESENT ALL INSURANCE CARDS & YOUR DRIVER'S LICENSE TO THE RECEPTIONIST.

FINANCIAL POLICY - AUTHORIZATION FOR USE OF HEALTH CARE INFORMATION

Payment is expected at the time of service. We will file for most insurance companies. It is our policy that all co-pays &/or deductible amounts are due and expected at the time of service. I understand that I am responsible for any "non-covered" services of my consent if deemed necessary. I accept the fee charged as a legal & lawful debt & agree to pay said fee, including any/all collections agency fees, finance charge, attorney fees, &/or court costs, if such be necessary.

I authorize Women's Health & Surgical Services to release any medical information requested by my health insurance carrier, Medicare, or any other third-party payers. WHSS may contact my insurance company or health plan administrator to obtain pertinent financial information concerning coverage & payments under my policy. I hereby authorize payment of insurance benefits be made on my behalf to WHSS & assign benefits to the provider indicated on the claim.

Women's Health & Surgical Services may use any telephone number or email associated with my account to contact me to service my account or collect monies. Methods of conatct may include using pre-recorded/artificial voice messages &/or use of automatic dialing device, as applicable.

I understand that I must notify WHSS 24 hours in advance to cancel office appointment(s) or I will be billed $25.00.

DATE:_____ SIGNATURE (parent/resp party):_____

NAME:_____ DOB:_____

THE NAMES LISTED BELOW ARE PERMITTED TO SHARE & KNOW MY HEALTH INFORMATION.

NAME:_____ RELATION:_____ PHONE:_____

NAME:_____ RELATION:_____ PHONE:_____

NAME:_____ RELATION:_____ PHONE:_____

NAME:_____ RELATION:_____ PHONE:_____

NAME:_____ RELATION:_____ PHONE:_____

** The names given above mean we can discuss results of ordered tests, labs, medication changes, appointments, or other things pertaining to your health care.

E-PRESCRIBING PBM CONSENT

By signing this consent, I am agreeing that Women's Health & Surgical Services can request & use my prescription medication history from other healthcare providers &/or third party pharmacy benefit payors for treatment purposes.

DATE:_____ SIGNATURE (parent/resp party):_____

CURRENT MEDICATION LIST (include any vitamins or non-prescription medicines)

NAME OF MEDICATION/DOSAGE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you take any type of blood thinner medication? YES NO

If yes, name of medication with dosage: _____

ALLERGIES

_____ _____

_____ _____

_____ _____

Women's Health & Surgical Services
John H. Gordon, D.O.

NAME:_____ DOB:_____

PATIENT HISTORY

Date of last pap smear & results _____

Date of last mammogram & results _____

Date of last colonoscopy & results _____

Date of last bone density & results _____

_____ No medical problems to report
_____ Diabetes
_____ Cancer
_____ Mental Health Disorder
_____ Heart Disease
_____ Hypertension
_____ Blood/Clotting Disorder
_____ Endocrine Disorder
_____ Liver Disease
_____ Kidney Disease
_____ Sexually Transmitted Disease
_____ Abnormal Pap Smear

REPRODUCTIVE HISTORY

Last Menstrual Period _____ Age of 1st Menstrual Cycle _____ Flow (heavy/light) _____

BIRTH CONTROL METHOD (PLEASE CIRCLE)

Nothing Withdrawal Condoms Diaphragm Oral Contraceptives

Depo Provera Nexplanon IUD Tubal Ligation Contraceptive Patch

Contraceptive Vaginal Ring Hysterectomy Vasectomy

If IUD/Nexpanon, please write the date of insertion: _____

PREGNANCY HISTORY

_____ Total pregnancies

_____ Full term _____ Abortions

_____ Premature _____ Ectopic

_____ Miscarriage _____ Living Children

Menopausal Status: _____

BLADDER HEALTH

Do you ever leak urine when you cough, laugh, sneeze or exercise?	YES	NO
Do you ever leak urine on the way to the bathroom or can't get there in time?	YES	NO
Do you have a history or recurrent urinary tract infections?	YES	NO
Do you go to the bathroom frequently &/or get up multiple times at night?	YES	NO

NAME:_____ DOB:_____

SURGICAL HISTORY

_____ No surgical history	_____ Heart surgery	_____ Oral surgery
_____ Hysterectomy	_____ Hernia Repair	_____ Sinus surgery
_____ Appendectomy	_____ Tubal ligation	_____ Cholecystectomy
_____ Kidney surgery	_____ Uterine ablation	_____ Dilation & curettage
_____ Back surgery	_____ Bladder Sling	_____ LEEP
_____ Left ovary removal	_____ Right ovary removal	_____ Fulguration of endometriosis

FAMILY MEDICAL HISTORY

_____ No family history	_____ Heart disease	_____ Osteoporosis
_____ Breast cancer	_____ Kidney disease	_____ Bleeding disorder
_____ Hypertension	_____ Thyroid disorder	_____ Diabetes
_____ Colon cancer	_____ Uterine cancer	_____ Stroke
_____ Mental illness	_____ Cervical cancer	_____ Auto immune disorder

SOCIAL HISTORY

TOBACCO USE: YES NO

At what age did you start? _____

Type of product used: _____ cigarettes _____ vape _____ chewing tobacco

Amount of use: _____ daily _____ some days, but not every day _____ 5 or less

Former smoker -- age you stopped smoking: _____

ALCOHOL USE: YES NO

Have you drank alcohol in the last year? _____

How often do you drink alcohol? _____ daily _____ socially _____ occasionally _____ never

RECREATIONAL DRUGS: YES NO

Type of use: _____

How often do you use? _____

DOMESTIC ABUSE

Are you currently experiencing any type of abuse? YES NO

Type of abuse: _____ verbal _____ physical _____ sexual

OTHER

Would you object to blood products in the event of an emergency? YES NO