

Women's Health Care of Western Colorado, P.C.

PATIENT REGISTRATION

Date _____
ID _____

Birth Date _____ Age _____
Primary Care Doctor _____

Women's Health Care Doctor _____

Married/Single/Widowed/Divorced (please circle)

PATIENT'S INFORMATION:

_____ Last Name First Name Middle Initial Maiden Name
Mailing Address: _____
P.O. Box Street City State Zip
Physical Address, if different: _____
Street City State Zip
Telephone: (H) _____; (W) _____; (C) _____ SS# _____
Occupation: _____ Employed by: _____ Referred by: _____

SPOUSE'S INFORMATION:

_____ DOB: _____
Last Name First Name Middle Initial
SS# _____ Employed by _____ Work # _____

ADDITIONAL CONTACT:

Name: _____ Phone # _____

INSURANCE INFORMATION:

_____ Relationship to Patient
Name of Primary Insured Party
Street Address City State Zip Telephone Number Social Security # Date of Birth
(1) _____ (2) _____ (1) _____ (2) _____
Name of Plan(s) Subscriber Number(s) Group Number(s)

I understand that I am the responsible party for services rendered. If my insurance company is billed, I authorize Women's Health Care of Western Colorado to furnish information to my insurance company concerning services provided, and I authorize payment of insurance benefits to Women's Health Care of Western Colorado. I also understand that I am responsible for charges not paid by my insurance company and will be responsible for all costs of collections including, but not limited to, interest, rebilling fees, court costs, attorney fees and collection agency costs.

SIGNED _____

DATED _____

PREGNANCY HISTORY (Include Miscarriages and/or Abortions)

| Year | Length of Pregnancy | Complications of/during Pregnancy | Gender | Present Health of Child |
|------|---------------------|-----------------------------------|--------|-------------------------|
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What are you and/or your partner using for birth control? _____ Date of last Pap Smear _____

First day of Last Period _____ Age Began _____ Regular _____ Duration of flow _____ Frequency of period _____

Smoking History: Now? _____ In the Past? _____ How Much? _____

Drinking History: Never _____ Socially _____ Every Other Day _____ Daily _____ Drug Use? _____

Family History Mother: Alive? _____ Age _____ Significant Illness or Cause of Death? _____

Father: Alive? _____ Age _____ Significant Illness or Cause of Death? _____

Has anyone in the immediate family ever had (circle): Tuberculosis? Diabetes? Epilepsy? Bleeding Disorder?

Heart Attack? Stroke? High Blood Pressure? Breast Cancer? Other Cancer? _____

When was your last immunization for Tetanus? _____ Pneumonia? _____ Hepatitis B? _____

Are you **ALLERGIC TO ANY MEDICATION**? PLEASE LIST: _____

| Current Medical Problems/Chronic Illnesses | Medications | Dose | Hospitalizations/Surgeries | Date |
|--|-------------|------|----------------------------|------|
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Please circle if you have had any of the following:

- | | | | | |
|----------------------|-----------------------|------------------------------|-----------------------------|---------------------------------|
| Severe headaches | Difficulty swallowing | Excessive swelling of ankles | Hemorrhoids | Venereal disease |
| Glasses | High blood pressure | Asthma | Gallbladder disease | Bothersome vaginal discharge |
| Glaucoma | Heart Disease | Coughing up blood | Severe abdominal pain | Heavy/painful menstrual periods |
| Serious ear problems | Shortness of breath | Palpitations | Change in bowel habits | Breast biopsy |
| Dentures | Chest pain | Excessive weight loss | Burning with urination | Pelvic infection |
| Ulcers | Heartburn | Prolonged nausea/vomiting | Urinating 3 or more x/night | Painful intercourse |
| Diarrhea | Black stools | Blood in stools | Blood in urine | Abnormal Pap smear |
| Diabetes | Thyroid trouble | Psychiatric care | Severe depression | Convulsions |
| Painful joints | Leg cramps | Broken bones | Bleeding disorder | Physical/Emotional abuse |