



WOMEN'S HEALTH
ADVANTAGE

Date: _____

Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security Number: _____

Marital Status: Married Single Divorced Separated Widowed Unknown Other

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail: _____

Employer: _____

Emergency Contact Name: _____

Emergency Contact Number: _____ Relationship: _____

Insurance Coverage Information:

Primary Insurance

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____

Relationship to Insured: () Self () Spouse () Child () Other _____

Policy Holder's Employer: _____

Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Secondary Insurance

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____

Relationship to Insured: () Self () Spouse () Child () Other _____

Policy Holder's Employer: _____

Insurance Company Name: _____

Policy Number: _____ Group Number: _____



ASSIGNMENT AND RELEASE

AGREEMENT TO PAY: In consideration for the services rendered and to be rendered by Women's Health Advantage to the above captioned patient, I (we) agree to pay Women's Health Advantage for all services and charges as ordered by the attending physician in accordance with the terms and policies of Women's Health Advantage. I (we) further agree and guarantee that in the event the account is not paid in accordance with financial arrangements made at discharge, or within thirty (30) days of discharge, to pay collection costs including court costs, reasonable attorney fees and interest from the date of demand, if this account is placed in the hands of an attorney for collection. Also, I (we) hereby acknowledge that Women's Health Advantage cannot assume responsibility for money, clothing, bridgework, dentures, eyeglasses, credit cards, or other personal items kept in my possession.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign to Women's Health Advantage and the attending physician(s), expenses or other surgical or treatment expenses and benefits which are due or that become due to me as a result of medical services to the patient listed below. I hereby authorize the payments to be paid directly to Women's Health Advantage for any services furnished by the physicians or certified physician assistants under their supervision. I understand I am responsible to Women's Health Advantage for payments made directly to me for any services or charges not covered by my insurance carrier or out-of-state workers compensation claim.

CONSENT FOR TREATMENT: I hereby voluntarily consent to medical care to include diagnostic procedures and medical treatment judged necessary by my physician or his designee. I acknowledge that no guarantees have been made to me as a result of this treatment. In addition to other consents given elsewhere in this document, I specifically consent to medical procedures and tests necessarily performed upon me to aid and assist in the diagnosis and treatment of my child. These tests may include tests for the presence or absence of alcohol or controlled substances.

RELEASE OF MEDICAL INFORMATION: I hereby authorize Women's Health Advantage and all physicians involved with my care to release information from my medical records as may be required to any person, corporation, or agency which is legally responsible or which Women's Health Advantage has good cause to believe is legally responsible, for processing and/or paying all of any part of Women's Health Advantage charges and/or professional fees; and, to any entity which has contracted with any insurer to conduct utilization or performance review. I hereby authorize Women's Health Advantage or any physician involved with my care to release information to any physician or health care facility to which I may be transferred for further medical care.

Signature of Patient or Guardian: _____ Date: _____

Signature of Spouse: _____ Date: _____

Signature of Witness: _____ Date: _____

WOMEN'S HEALTH ADVANTAGE: PATIENT HEALTH HISTORY

Patient Name: _____ Age: _____ Date of Birth: _____

Family Doctor: _____ Referred By: _____

Reason for Visit: _____

PAST MEDICAL HISTORY

CONDITION	CURRENT	HISTORY	NO	CONDITION	CURRENT	HISTORY	NO
Abnormal PAP Smear				Herpes			
Anemia				Human Immunodeficiency Virus (HIV)			
Anesthesia Complications				Human Papilloma Virus (HPV)			
Anxiety				Hypertension			
Asthma				Infertility			
Blood Clot in Legs or Lungs				Kidney Stone			
Blood Transfusion				Liver Disease			
Breast Disorder				Lupus			
Cancer of the Breast				Migraine			
Cancer, other				Mitral Valve Prolapse			
Cardiovascular Disease				Pelvic Inflammatory Disease			
Chlamydia				Rheumatic Fever			
Depression				Seizures/Convulsions			
Diabetes				Stroke			
Endometriosis				Syphilis			
Epilepsy				Thyroid Disorder			
Fibromyalgia				Trichomoniasis			
Gonorrhea				Tuberculosis			
Heart Murmur				Ulcer			
Hepatitis B				Urinary Tract Infection			
Hepatitis C							
Date of Last Pap Smear: _____ Normal Abnormal				Date of Last Mammogram: _____ Normal Abnormal			
Date of Last DEXA Scan: _____ Normal Abnormal				Date of Last Colonoscopy: _____ Normal Abnormal			
Other: _____							

OPERATIONS/SURGERIES

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1)		4)	
2)		5)	
3)		6)	

MEDICATIONS – include prescriptions, over the counter, herbals & vitamins

MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN
1)		
2)		
3)		
4)		
5)		
6)		

MEDICATION ALLERGIES

Medication	Reaction

FAMILY MEDICAL HISTORY – Do any of your children, siblings, or parents have any of the following?

ILLNESS	YES	RELATIONSHIP	ILLNESS	YES	RELATIONSHIP
NONE			Cardiovascular Disease		
ADOPTED			Depression		
Blood clot in leg or lungs			Diabetes		
Cancer, Breast			Hypertension		
Cancer, Colon			Osteoporosis		
Cancer, Ovarian			Polyp – anal/rectal/colon		
Cancer, Uterine			Stroke		
Cancer, Other			Thyroid Disorder		

GENETIC HISTORY/SCREENING - Self, partner, or other family member

CONDITION	YES	RELATIONSHIP	CONDITION	YES	RELATIONSHIP
Cats – do you have exposure?			Ingestion of uncooked meat		
Chickenpox			Patient > age 35 years as of EDC		
Congenital Heart Defect			Phenylketonuria (PKU)		
Cystic Fibrosis			Rh Sensitized		
DES Exposure			Sickle Cell Anemia		
Diabetes – self only			Tay-Sachs Disease		
Down Syndrome			Thalassemia (Italian, Greek, Mediterranean)		
Infertility			Uterine Defect		

REPRODUCTIVE HISTORY

Age of first menses:	Cycle Interval (Number of days from start to start):
Menses duration (Number of days of bleeding):	Flow (Light, Medium, or Heavy):
Number of Tampons/day:	Number of Pads/day:
Last Menstrual Period: / / (Date)	Certain of LMP Date (yes or no)?
Menopause Status (Pre, Peri or Post):	Age at Menopause:
Method of Birth Control:	Clots (yes or no)?
Breakthrough Bleeding (yes or no):	On HRT (yes or no)?

PREGNANCY HISTORY

DATE	GESTATIONAL AGE	HOURS IN LABOR	BIRTH WEIGHT	SEX	TYPE OF DELIVERY	ANESTHESIA	EARLY LABOR	COMPLICATIONS	HOSPITAL

SOCIAL HISTORY

Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Spouse/Partner Name:
Occupation:
Alcohol: <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Former Amount per Week:
Drugs: <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Former Type:
Smoking: <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Former Amount per Day:
Exercise: <input type="checkbox"/> Active <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Minimal <input type="checkbox"/> None (Sedentary)