PATIENT REGISTRATION

Date____________________
ID_____________________

Women's Health Care Doctor_____________

Birth Date________________________ Age____
Primary 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: ____________________________________ ____________________________
Name of Primary Insured Party *Relationship to Patient*

______________________________ __________________ _________-________-________ ____/____/_____
Street Address City State Zip *Telephone Number* *Social Security #* Date of Birth

(1)_______________ (2)_____________ (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

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

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