PATIENT NAME: _____ _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE- HOME: (_____) _____ CELL: (_____) _____

EMAIL ADDRESS: _____

CHECK ONE: F/T STUDENT_____ P/T STUDENT_____ EMPLOYED_____ UNEMPLOYED_____

CHECK ONE: SINGLE_____ MARRIED_____ OTHER_____

PATIENT

EMPLOYER/SCHOOL: _____

EMPLOYER/SCHOOL PHONE #: _____

DATE OF BIRTH: _____SS#: _____

SPOUSE / GUARDIAN

NAME: _____

TELEPHONE: WORK (____) _____

DATE OF BIRTH: _____SS#: _____

EMERGENCY CONTACT (NAME & NO.): _____

CONTACT PREFERENCE:

☐ CELL PHONE:_____

☐ HOME PHONE _____

☐ EMAIL:_____

PATIENT NAME_____
AGE_____

PRIMARY INSURANCE INFORMATION

INSURANCE CO.: _____

CLAIMS ADDRESS: _____

CITY, STATE ZIP: _____

GROUP NO: _____

POLICY/ID#: _____

SECONDARY INSURANCE INFORMATION

INSURANCE CO.: _____

CLAIMS ADDRESS: _____

CITY, STATE ZIP: _____

GROUP NO.: _____

POLICY/ID#: _____

Assignment of Insurance Benefits and Authorization to release Information

I authorize payment of medical benefits to Elite Women's Care Center, PA for any and all services not paid in full at the time services are rendered.

I authorize Elite Women's Care Center, PA to release any medical information as necessary for the completion of my insurance claims to any insurance carrier, health, or hospital plan.

PATIENT_____ DATE_____

PATIENT'S LEGAL GUARDIAN_____ DATE_____

PATIENT NAME_____
AGE_____

PAST HISTORY: **CIRCLE ALL THAT APPLY**

Arthritis
Asthma
Breast Tumor
Diabetes
Heart Attack
Heart Murmur
Hepatitis
High Blood Pressure
High Cholesterol
Intestinal Bleeding
Kidney Infection
Kidney Stone
Migraine Headaches
Mitral Valve Prolapse
Neurological Disease
Osteoporosis
Paralysis
Pneumonia
Rheumatic Fever
Thromboembolic Events
Thyroid Problems
Other Heart Disease_____
Other Kidney Disease_____
Infectious Diseases (TB, HIV, etc..)_____
Other Lung Disease_____
Other Genetic/Inherited Disease _____

Number of:

____Pregnancies
____Deliveries
____Miscarriages
____Abortions
____Living Children

Please list pregnancies in chronological order:

MM/DD/YY	Sex	Wt	Type of Delivery	Anesthesia	Complications

List all previous surgeries (Type and Approximate Date)

_____

PATIENT NAME_____
AGE_____

_____

Will you permit a blood transfusion for medical reasons? _____

Date of last menstrual cycle: _____ Are your cycles regular? _____

Describe any problems with your cycles: _____

Current type of birth control_____ Do you want to change birth control? Y N

What birth control options are you interested in? _____

Did your mother take DES or other hormones while pregnant with you? _____

Regarding your female organs: **Circle all that apply**

Abnormal Bleeding

Chlamydia/Gonorrhea/Syphilis/Herpes

Genital Warts

Inf Pelvic Infections

TubTubal (Ectopic) Pregnancy

Tumor of the Uterus or Ovaries

Have you ever had an abnormal Pap Smear? _____ Treatment? _____

Are you sexually active? _____ Any concerns or discomfort? _____

List all currently used Medications (Please include herbal medications and compounded drugs)

_____

List allergies to medications_____

Do you drink alcohol? _____If yes, number of drinks, beers, glasses of wine per week_____

Do you smoke? _____If yes, number of packs per day/week _____

Are you using any other drugs? _____ Type? _____

Family History: Is there a member of your family with a history of:

PATIENT NAME_____
AGE_____

_____Cancer Who/Type?_____

_____Congenital (Inherited) Disease Who?_____

_____Diabetes Who?_____

_____Heart Disease Who?_____

_____High Blood Pressure Who?_____

_____High Cholesterol Who?_____

_____Kidney Disease Who?_____

_____Mental Retardation Who?_____

_____Osteoporosis Who?_____

_____Twins Who?_____

Date of last Pap Smear_____ Results_____

Date of last Mammogram_____ Results_____

Date of last bone density_____ Results_____

Reason for today's visit

_____

_____

What changes have there been in your life recently?

_____

_____

Pharmacy Name and Phone Number_____

Do you need 1 month or 90 day prescriptions? _____

How did you hear about us? ___ Katy Magazine ___ Absolutely Katy ___ Prior Patient

___ Email ___ Friend/Relative ___ Yellow Pages ___ Primary Care ___ Consultant

PATIENT NAME_____

AGE_____