



(Office use only)  
Acct #: \_\_\_\_\_ Entered By: \_\_\_\_\_

**PATIENT REGISTRATION FORM**  
*PLEASE PRINT CLEARLY*

Today's Date \_\_\_\_\_

Social Security Number \_\_\_\_\_ Driver's License Number \_\_\_\_\_

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **MI** \_\_\_\_\_

Nickname/Maiden Name \_\_\_\_\_ email \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Are we permitted to contact you at all of the numbers listed above?  Yes  No

Age \_\_\_\_\_ Date of Birth \_\_/\_\_/\_\_ Sex:  F  M Marital Stat:  Single  Married  Divorced  Other

Race: **Optional**  Black  White  Asian  Hispanic  Other

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Are you a student?  Yes  No School Name \_\_\_\_\_

**EMERGENCY CONTACT**

Nearest relative not living with you \_\_\_\_\_ Relationship \_\_\_\_\_

Address, City and Zip \_\_\_\_\_ Phone \_\_\_\_\_

**RESPONSIBLE PARTY OR PRIMARY INSURANCE SUBSCRIBER**

Relationship to patient:  Self  Spouse  Child  Other: \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_/\_\_/\_\_ Sex:  F  M

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **MI** \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

**EMPLOYER PROVIDING INSURANCE**

Employer Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**INSURANCE INFORMATION** (PLEASE PRESENT ALL INSURANCE I.D. CARDS TO THE RECEPTIONIST AT THIS TIME)

**Primary** Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Insured Name \_\_\_\_\_ Employer \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Copay Amount \$ \_\_\_\_\_ or Yearly Deductible \$ \_\_\_\_\_

**Secondary** Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Insured Name \_\_\_\_\_ Employer \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Copay Amount \$ \_\_\_\_\_ or Yearly Deductible \$ \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_

**PHARMACY:** \_\_\_\_\_

Do you have a living will?  Yes  No

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I hereby authorize Tampa Bay Women’s Care to furnish all information to insurance carriers concerning my illness, and/or treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents.

I understand that I am responsible for any amount not covered by insurance; this includes any course of treatment that is not a covered benefit (this includes HMO products). I understand that I am responsible for notifying Tampa Bay Women’s Care of any changes in my insurance coverage. If I am delinquent in updating this information and the charges are denied, I understand that I will be held responsible for these charges.

**We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below the name(s) of individuals you authorize our office to discuss your care with. Your PHI will be disclosed to the individual(s) listed below until you notify us otherwise in writing.**

\_\_\_\_\_  
\_\_\_\_\_

**I acknowledge that I have received a copy of Tampa Bay Women’s Care “Notice of Privacy Practices”. I have read and understand the above and agree to comply.**

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Parent/Guardian Signature & Relationship:** \_\_\_\_\_

# CONTEMPORARY WOMEN'S CARE

## ANNUAL UPDATE

Date: \_\_\_\_\_

In order to provide you with more effective medical care, we need certain information about your recent medical history. Please take a few minutes to answer the following questions. Thank you.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_ e:mail: \_\_\_\_\_

1. What is the reason for your visit here today? \_\_\_\_\_  
\_\_\_\_\_
2. Since your last visit, have you had any operations, serious illness, injuries? \_\_\_\_\_  
If yes, Please explain: \_\_\_\_\_
3. Please list any medications you're taking \_\_\_\_\_  
\_\_\_\_\_
4. Please list any vitamins, herbs, calcium, etc. \_\_\_\_\_  
\_\_\_\_\_
5. Do you currently smoke? \_\_\_\_\_ How much? \_\_\_\_\_
6. Do you currently drink alcoholic beverages? \_\_\_\_\_ How much? \_\_\_\_\_
7. Do you currently drink caffeinated beverages? \_\_\_\_\_ How much? \_\_\_\_\_
8. Do you use any recreational drugs? \_\_\_\_\_ Explain \_\_\_\_\_
9. Do you get any form of regular exercise? \_\_\_\_\_ Type? \_\_\_\_\_
10. Have you had a Bone Density Test? \_\_\_\_\_ When? \_\_\_\_\_ Results \_\_\_\_\_
11. Are you sexually active? \_\_\_\_\_ New sexual partners since your last visit? \_\_\_\_\_ Age of 1st intercourse? \_\_\_\_\_ Total# of partners? \_\_\_\_\_
12. Have you had a colonoscopy? \_\_\_\_\_ When? \_\_\_\_\_ Results \_\_\_\_\_
13. Have you had any changes in your menstrual periods? \_\_\_\_\_
14. Please indicate your present method of contraception \_\_\_\_\_
15. When did your last menstrual period begin? \_\_\_\_\_
16. Have you been in a relationship in which you are being hurt or threatened, emotionally or physically? \_\_\_\_\_ Presently \_\_\_\_\_ Past \_\_\_\_\_ No
17. Please indicate any changes in your family's health this past year \_\_\_\_\_  
\_\_\_\_\_
18. Who is your primary care physician? \_\_\_\_\_
19. Does your insurance cover preventative well woman care? \_\_\_\_\_

## REVIEW OF SYSTEMS

Please circle any problems you are currently having. Please also circle "none", if that applies.

1. **General:** none / fever / chills / weight loss / weight gain / fatigue / night sweats / insomnia / hot flashes
2. **Eyes:** none / vision changes / corrective lenses
3. **Ear, Nose & Throat:** none / headache / hearing loss / ulcers / sinusitis
4. **Cardiovascular:** none / swelling of ankles / chest pain / palpitations / dizzy spells / fainting / difficulty breathing while walking, while laying flat
5. **Respiratory:** none / shortness of breath / wheezing / cough / coughing up blood / emphysema / history of TB
6. **Gastrointestinal:** none / constipation / diarrhea / bloody stool / nausea / vomiting / indigestion / fecal incontinence / flatulence / pain / problems swallowing
7. **Genitourinary:** none / pain or burning with urination / night time urination / frequent urination / leaking urine / blood in urine / trouble emptying bladder / sexual difficulties / painful sex / abnormal or painful periods / abnormal bleeding / vaginal dryness / vaginal discharge / itch / odor / PMS / infertility / bleeding between periods
8. **Musculoskeletal:** none / muscle weakness / muscle pain / joint swelling / joint pain / back pain / limitations on physical activity
- 9a. **Skin:** none / dry / rash / itch / ulcers / pigmented lesions / change in moles
- 9b. **Breasts:** none / pain / mass / discharge
10. **Neurologic:** none / fainting / seizures / numbness / severe memory problems / Migraine headaches / sleep problems / trouble walking / ringing in ears
11. **Psychiatric:** none / severe anxiety / feelings of depression / crying spells / mood swings
12. **Endocrine:** none / diabetes / thyroid problems / hair loss / heat or cold intolerance / excessive sweating / excessive thirst
13. **Hematologic:** none / bleeding / bruising / swollen lymph nodes
14. **Allergic:** none / drug allergies \_\_\_\_\_  
\_\_\_\_\_

Are there any problems you would like to discuss today? \_\_\_\_\_  
\_\_\_\_\_

Would you like to discuss the HPV vaccine? Yes \_\_\_\_\_ No \_\_\_\_\_

Patient Signature \_\_\_\_\_ Physician Signature \_\_\_\_\_ Date \_\_\_\_\_