



(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 _____

