

**WOMEN'S HEALTHCARE CENTER  
PATIENT INFORMATION**

DATE: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

NAME: \_\_\_\_\_

FIRST

MI

LAST

ADDRESS: \_\_\_\_\_

STREET

CITY

STATE

ZIP CODE

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_\_) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: (\_\_\_\_\_) \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ SPOUSE NAME: \_\_\_\_\_

SPOUSE DATE OF BIRTH: \_\_\_\_\_ SPOUSE SOCIAL SECURITY# \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE (\_\_\_\_\_) \_\_\_\_\_

PLEASE LIST A FRIEND OR RELATIVE (OTHER THAN SOMEONE AT YOUR ADDRESS) WHO CAN BE REACHED IN CASE OF AN EMERGENCY.

NAME \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

INSURED'S RELATIONSHIP TO PATIENT \_\_\_\_\_

**RESULTS NOTIFICATION:**

UPON RECEIPT AND REVIEW OF TEST RESULTS, HOW DO YOU WISH TO BE NOTIFIED?

BY PHONE: #

ARE WE ABLE TO LEAVE A MESSAGE ON AN ANSWERING MACHINE: YES NO

ARE WE ABLE TO LEAVE A MESSAGE WITH A FAMILY MEMBER: YES NO

BY MAIL:(THIS OPTION ONLY IF UNABLE TO CONTACT YOU IN OTHER FORMS) YES NO

IF ANY OF YOUR TEST RESULTS COME BACK WITH ABNORMAL RESULTS, WE WILL MAKE EVERY EFFORT TO CONTACT YOU BY PHONE. PLEASE MAKE SURE THAT WE HAVE ALL OF THE CURRENT PHONE NUMBERS TO REACH YOU. IF WE ARE UNABLE TO REACH YOU WITHIN A REASONABLE AMOUNT OF TIME, WE WILL CONTACT YOU BY MAIL ASKING YOU TO CONTACT OUR OFFICE TO DISCUSS RESULTS. WE DO NOT WANT YOUR NOTIFICATION OF RESULTS DELAYED DUE TO UNSUCCESSFUL ATTEMPTS OF CONTACTING YOU.

I HEREBY ASSIGN MY INSURANCE BENEFITS UNDER THE ABOVE PLAN TO WOMEN'S HEALTHCARE CENTER FOR DR. CHATTERJI, DR. LAMOUTTE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS ASSIGNMENT. I ALSO HEREBY AUTHORIZE THE RELEASE OF INFORMATION REQUESTED IN THE COURSE OF MY EXAMINATION AS NEEDED. IF MY ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY I MAY BE RESPONSIBLE FOR ATTORNEY AND COURT FEES AND MAY NOT BE ABLE TO SEEK CARE AT WOMEN'S HEALTHCARE CENTER ANY LONGER, **ALL FEES MUST BE PAID AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS, PERSONAL CHECKS AND CASH.**

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

WOMEN'S HEALTHCARE CENTER  
PATIENT HISTORY FORM

NAME \_\_\_\_\_

ALLERGIES TO MEDICATION \_\_\_\_\_

MEDICATIONS YOU ARE TAKING NOW \_\_\_\_\_

AGE YOUR PERIOD STARTED \_\_\_\_\_ REGULAR? YES NO CRAMPS? YES NO

HOW MANY DAYS APART USUALLY \_\_\_\_\_ HOW MANY DAYS OF FLOW USUALLY \_\_\_\_\_

DATE OF LAST PERIOD \_\_\_\_\_ MENOPAUSE? YES NO WHEN \_\_\_\_\_

ANY SPECIAL PROBLEMS OR CONCERNS WITH PERIODS \_\_\_\_\_

ARE YOU USING ANY FORM OF BIRTH CONTROL NOW? \_\_\_\_\_ IF YES, WHAT TYPE \_\_\_\_\_

HAVE YOU HAD A HYSTERECTOMY? YES NO WHEN \_\_\_\_\_

NUMBER OF PREGNANCIES INCLUDING MISCARRIAGES? \_\_\_\_\_

NUMBER OF CHILDREN BORN ALIVE \_\_\_\_\_ NUMBER OF MISCARRIAGES OR ABORTIONS \_\_\_\_\_

ANY SPECIAL PROBLEMS OR CONCERNS WITH PREGNANCIES \_\_\_\_\_

PLEASE LIST ANY SURGERY THAT YOU HAVE HAD AND PLEASE GIVE DATES IF ABLE TO \_\_\_\_\_

MEDICAL ILLNESSES (PLEASE CIRCLE IF APPROPRIATE) THYROID DISEASE HIGH BLOOD PRESSURE

ASTHMA DIABETES HEART DISEASE KIDNEY DISEASE EPILEPSY/SEIZURES CANCER

DO YOU HAVE ANY FAMILY MEMBERS WHO HAVE OR HAVE HAD ANY OF THE ABOVE CONDITIONS:

HAVE YOU EVER BEEN A VICTIM OF DOMESTIC VIOLENCE? YES NO  
IF YES PLEASE STATE WHEN: \_\_\_\_\_

DO YOU DRINK ALCOHOL? YES NO  
IF YES HOW OFTEN? \_\_\_\_\_

DO YOU SMOKE? YES NO HOW MUCH? \_\_\_\_\_ PACKS PER DAY /WEEK

LAST DATE FOR IMMUNIZATIONS OR ROUTINE SCREENINGS: FLU SHOT \_\_\_\_\_ MMR \_\_\_\_\_  
TETANUS \_\_\_\_\_ HEPATITIS \_\_\_\_\_ CHOLESTEROL \_\_\_\_\_ MAMMOGRAM \_\_\_\_\_  
PAP SMEAR \_\_\_\_\_

