# Patient Registration Form (eCW)

**PATIENT INFORMATION** (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address: _____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ☐ _____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

**RESPONSIBLE PARTY INFORMATION** (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____/DD _____/YYYY _____

Telephone _____ E -Mail Address _____

**PRIMARY INSURANCE INFORMATION** (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

**SECONDARY INSURANCE INFORMATION** (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

**PHARMACY**

Pharmacy Name / Phone Number _____ (_____) _____

Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

***Patient (or Responsible Party) Signature*** _____ ***Date*** _____

**Name:** _____ **DOB**_____

**Please list all your current medications: (including over the counter, vitamins/minerals/herbal supplements)**

| Medication | Dose | Frequency | Prescribing Dr. |
|---|---|---|---|
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Medical History: (Please check all appropriate columns)

_____ No Known Medical Problems _____ Adopted

| | You | Specific family member/Age | Details/Dates: |
|---|---|---|---|
| Abuse: Domestic, Emotional, Sexual | | | |
| Alcoholism | | | |
| Asthma: Adult/Childhood/Exercise | | | |
| Birth Defects | | | |
| Blood Clots in Legs or Lungs | | | |
| Blood Transfusion | | | |
| Breast Problems (specify) | | | |
| Cancer | | | |
| Ovarian | | | |
| Breast | | | |
| Colon | | | |
| Other (specify) | | | |
| Depression | | | |
| Diabetes | | | |
| Heart Disease | | | |
| Hepatitis | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Kidney Problems | | | |
| Liver Disease | | | |
| Lupus | | | |
| Osteoporosis | | | |
| Seizures | | | |
| Stomach/Bowel/Gall Bladder Problems | | | |
| Stroke | | | |
| Thyroid Disorder | | | |
| Other Medical Problems (specify) | | | |
| | | | |
| | | | |
| | | | |

**Do you have any medical allergies? Y/N (please specify drug and reaction)**

| Drug: | Reaction: |
|---|---|
| Latex? Y/N | |
| Iodine? Y/N | |
| Penicillin? Y/N | |
| Sulfa? Y/N | |
| Other? | |
| Other? | |

**Gynecologic History**

| | |
|---|---|
| Have you ever had a mammogram? | Y/N Most recent _____ Normal/Abnormal? |
| Do you do monthly self breast exams? | _____yes _____no |
| When was your last pap test? | ____/____/____ |
| Have you ever had an abnormal pap test? | _____no yes: date/result _____ |
| What was your treatment? ___LEEP ___Cone Biopsy ___Other | |
| Have you ever had a sexually transmitted disease? | |
| ___herpes ___genital warts ___trichomoniasis ___chlamydia ___gonorrhea | |
| Have you ever had a bone density scan? | ____/____/____ Result: |
| Have you ever had a colonoscopy? | _____no _____yes when/result_____ |

**Menstrual and Sexual History**

| | |
|---|---|
| How old were you when you first began menstruating? | _____years old |
| What was the first day of your last period? | _____/_____/_____ |
| How many days pass between the first day of each period? | _____days pass |
| How long do your periods last? | _____days long |
| On your heaviest day how many pads/tampons do you use? | _____pads and/or _____tampons |
| How do you rate your menstrual pain? | ____mild ____moderate ____severe |
| How do you treat your pain? | |

| | |
|---|---|
| Have you ever had sex? | _____yes _____no |
| Are you currently in a sexual relationship? | _____yes _____no |
| Your sexual preference is: | _____men _____women _____both |
| Have had any new partners since your last visit? | _____yes _____no |
| What do you use to prevent pregnancy? | (specify) |

| | |
|---|---|
| How old were you when you went through menopause? | _____years old |
| Did you have a hysterectomy? | _____yes _____no |
| If yes, when? | _____years old |
| Why was this done? | (specify) |
| Do you still have your ovaries? | _____yes _____no |
| Do you still have your cervix? | _____yes _____no |

**Pregnancy History**

| | |
|---|---|
| How many times have you been pregnant? | _____ |
| How many times have you given birth? | _____ |
| Have you ever been treated for post-partum depression? | Y/N |
| Did you have any complications with your pregnancies? | Y/N |
| (specify) | |
| | |

**Please list all of your pregnancy outcomes:**

| Date: | M/F | Weight | # of weeks | Delivery type | Epidural? | Notes: |
|---|---|---|---|---|---|---|
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**Surgical History:** **Date/Details:** **Date/Details:**

| | | | |
|---|---|---|---|
| Laparoscopy | | Breast Surgery | |
| C-Section | | Bowel Surgery | |
| Tubes Tied | | Cosmetic | |
| Gallbladder | | Other (Specify) | |
| Appendix | | | |

| Social History: |
|---|
| Do you smoke? Y/N _____packs/day or _____c/day How long? _____ |
| Do you drink alcohol? Y/N _____ drinks/week |
| Do you use recreational drugs? |
| _____Marijuana _____ Cocaine/Crack _____ Heroin _____Other |
| Do you drink caffeine? Y/N _____drinks/day |
| What is your occupation? (specify) |

**Are you experiencing any of the following symptoms as an *ongoing* problem?**

**None**

Fever

Chills

Night Sweats

Unexplained Weight Gain

Skin Changes

Eccessive Hair Loss

Difficulty Sleeping

Fatigue

Anxiety

Depression

Diarrhea

Constipation

Painful Urination

Leaking Urine

Urinary Frequency

Bloody Stool

Swelling

Muscle Weakness

Genital Sores

Unexplained Rash

Breast Tenderness

Vaginal Discharge

Shortness of Breath

Chest Pains

Change in Appetite

Nausea

Vomiting

Heavy Periods

Menstraul Pain

Irregular Cycles

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by an alternate means, such as sending correspondence to the individuals office instead of the individuals home.

Patient Name (PLEASE PRINT)_____ DOB _____

**I wish to be contacted in the following manner (Check all that apply)**

☐ Home Phone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other (Spouse, Children, Etc)

_____
_____
_____

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Cell Phone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

**Patient Name: _____ DOB:_____**

I, the undersigned, in consideration for services being rendered by Lone Tree Woman's Care, understand and agree to the following:

1. I understand that payment for co-pays, deductibles, coinsurance and account balances are payable at the time of service.
2. I hereby authorize Woman's Care of Colorado to file a claim with my insurance carrier and I authorize payment for medical services to Woman's Care of Colorado.
3. I have read and understand the Notice of Privacy Practices. I give my consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations.
4. I authorize release of any and all medical records and information necessary for continuation of care and for processing any claims associated with services I receive in this office.
5. I understand that my insurance benefits and referral requirements are my responsibility. Lone Tree Woman's Care will assist me in any area possible, but ultimately, I am responsible to understand my benefits and obtain any referrals necessary.
6. I will inform Woman's Care of Colorado anytime my personal information or insurance coverage has changed.
7. I will keep my account balance current. In the event I fail to pay my account balance.
8. I understand Woman's Care of Colorado reserves the right to not continue care due to excessive late arrivals to appointment or "no-show" to scheduled appointments. It is important to cancel within twenty-four hours of your scheduled appointment.

***My signature below indicates I agree to all the terms set above.***

_____ _____

Patient or *Personal Representative Signature Date

*If this consent is signed by a personal representative on behalf of the patient, complete the following:

_____

Personal Representative's Name

_____

Relationship to Patient: