Dr. Theresa Robinson

PATIENT INFORMATION **(Please Print)**

Patient's Name (Last) ________________________________ (First) _________________________(MI) ________________

Address _________________________________City_________________________ State ___________ZIP ___________

Home Phone _____________________________Cell _________________________ Work Phone ____________________

Occupation _____________________________________Employer____

E-Mail Address: ____

Date of Birth MM________/DD ________/YYYY __________ Sex ☐F- Female ☐M-Male

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

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

Pharmacy _____________________________________ ,Pharmacy Phone, ____

Social Security Number ________- ______-____________ Referred by____

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

Spouse/Partner Name ______________________________ Social Security Number ________- ______-___________

Spouse/Partner Employer____ Work Phone __________________________

Emergency Contact Last Name _______________________________ First Name ______________________________

Phone Number __________________________________Relationship _______________Do you have a living will? ☐Yes ☐ No

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

Insurance Company/Phone Number ____Phone No.(______) _______ _________

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 ____Phone No.(______) _______ _________

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_______

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* ______________________________

©HCA, Inc. 2012

Dr. Theresa Robinson

Patient History

Name: ____________________ **Date**: ____________________

Why are you being seen today? ____________________

List all medications you are currently taking?

____

____

Medical History

Mark all the following medical conditions that you have:

Condition	Yes	No	Condition	Yes	No
Asthma/respiratory disease	[ ] Yes	[ ] No	Hepatitis	[ ] Yes	[ ] No
Headache/Migraine	[ ] Yes	[ ] No	Depression	[ ] Yes	[ ] No
High blood pressure	[ ] Yes	[ ] No	HIV	[ ] Yes	[ ] No
Diabetes	[ ] Yes	[ ] No	Cervical cancer	[ ] Yes	[ ] No
Kidney disease	[ ] Yes	[ ] No	Ovarian cancer	[ ] Yes	[ ] No
Anemia	[ ] Yes	[ ] No	Breast cancer	[ ] Yes	[ ] No
Heart disease	[ ] Yes	[ ] No	Colon cancer	[ ] Yes	[ ] No
Hypertension	[ ] Yes	[ ] No	Melanoma/skin cancer	[ ] Yes	[ ] No
Lung disease	[ ] Yes	[ ] No	Thyroid disease	[ ] Yes	[ ] No
Polycystic Ovarian Syndrome (PCOS)	[ ] Yes	[ ] No			
Bleeding disorder/Blood clots	[ ] Yes	[ ] No			

Other: ____________________

Medication Allergies:

____

____

Food Allergies:

____

____

Personal History

Do you smoke? [ ] Yes [ ] No [ ] Socially Do you drink? [ ] Yes [ ] No [ ] Socially

Do you use illegal drugs? [ ] Yes [ ] No Do you drink caffeine? [ ] Soda [ ]Coffee [ ] Tea

Gynecological History

First day of your last period?____________________

At what age did you have your first period? ____________

Do your periods come at regular intervals? [ ] Yes [ ] No,

If yes, how many days? _________________If no, what are the longest and the shortest intervals?______________

How many days do your period last? _____________ Do you have pain when you have your periods? [ ] Yes [ ] No

Do you have spotting before the actual menstrual flow? [ ] Yes [ ] No If yes, how many days?____________

When was your last pap smear? __________________ Have you ever had an abnormal pap? [ ] Yes [ ] No

Are you sexually active? [ ] MEN [ ] WOMEN [ ] BOTH [ ] N/A

If yes, do you have pain during intercourse? [ ] Yes [ ] No

Do you use birth control? [ ] Yes [ ] No [ ] N/A If yes, which method? _______________________________

Have you had an infection of your ovary and/or tubes (PID)? [ ] Yes [ ] No

Have you had a sexual transmitted disease such as gonorrhea, syphilis or chlamydia? [ ] Yes [ ] No

If yes, please list? ____

Have you ever had been pregnant? [ ] Yes [ ] No

If yes, please tell us the number of:

Natural Births ________ C-Sections __________

Miscarriages _________ Terminations ________

Prior Surgeries/Hospitalizations?

____

Last Mammogram__________________ Last Bone Density _______________Last Colonoscopy _______________

Family History

Do any of your family members have: (Mother, Father, etc…….) Are you adopted? [ ] Yes [ ] No

High blood pressure? [ ] Yes [ ] No If yes, who? _________________________________

Diabetes? [ ] Yes [ ] No If yes, who?_________________________________

Heart disease? [ ] Yes [ ] No If yes, who? _________________________________

Stroke? [ ] Yes[ ] No If yes, who? _________________________________

Breast cancer? [ ] Yes [ ] No If yes, who? _________________________________

Colon cancer? [ ] Yes [ ] No If yes, who? _________________________________

Cervical cancer? [ ] Yes [ ] No If yes, who? _________________________________

Ovarian cancer? [ ] Yes [ ] No If yes, who? _________________________________

Melanoma/skin cancer? [ ] Yes [ ] No If yes, who? _________________________________

Other cancers? [ ] Yes [ ] No If yes, who?________________________________

Woman's Health Group

PATIENT NAME____DATE OF BIRTH____________

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. **____________(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, Woman's Health Group may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. **___________(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that Woman's Health Group may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. **___________(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to Woman's Health Group any insurance or other third-party benefits available for health care services provided to me. I understand that Woman's Health Group has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Woman's Health Group, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. **______________(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Woman's Health Group by the Medicare or Medicaid program.

5. **______________(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for Woman's Health Group, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Woman's Health Group or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Woman's Health Group or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. **______________(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X____Date_________________

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse
Parent
Legal Guardian

Guarantor
Healthcare Power of Attorney
Other (please specify)_____________________________________