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* _____

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:

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	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify)_____