

## Women Specialists of Katy REGISTRATION FORM

PATIENT INFORMATION				
Patient's name:			Marital status (circle one): Single / Married / Divorced / Separated / Widowed	
Social Security number:	Drivers License number:	Drivers License state:	Birth date: / /	Age:
Email address:				
Home phone : (    )		Cell phone : (    )		May we leave results on your voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street address:				
City:	State:	Zip Code:		
Employer:	Work phone : (    )	Occupation:		
Street address:				
City:	State:	Zip Code:		
How did you hear about us?	<input type="checkbox"/> Friend	<input type="checkbox"/> Doctor	<input type="checkbox"/> Other	

INSURANCE INFORMATION			
Policy holder's name:	Birth date: / /	Phone : (    )	Employer:
Policy holder's Social Security number:		Policy holder's Drivers License number:	
Insurance company:	Insurance type (circle one): HMO / PPO / POS / EPO		
Group number:	Policy number:		

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone: (    )	Work phone: (    )
<p>Please be aware that we will accept and file a claim with your insurance, provided that you have a current insurance card and a contracted plan. All other claims must be filed by you. You are responsible for keeping our office informed of any changes in coverage. Your signature on this document authorizes Women Specialists of Katy to submit claims for services rendered without obtaining your signature on each claim filed.</p> <p>I authorize my insurance company to pay and hereby assign Women Specialists of Katy all benefits, payable for services rendered. I understand that I am financially responsible for all charges.</p>			
<hr style="width: 100%;"/> <i>Authorization signature</i>		<hr style="width: 100%;"/> <i>Date</i>	

**ALLERGIES**

Drug	Reaction

**MEDICATIONS**

Drug	Dose	How often do you take this?

**MEDICAL HISTORY**

Please list all pregnancies, including miscarriages and terminations.

Date of delivery	Sex	Weeks Pregnant	Baby's weight	Hours in labor	C-section or vaginal	Hospital	Complications
/ /							
/ /							
/ /							
/ /							
/ /							
/ /							

**Gynecological History**

Last pap smear: / /	Any abnormal pap smears? <input type="checkbox"/> Yes <input type="checkbox"/> No	Details:
Last Mammogram: / /	Any abnormal mammograms? <input type="checkbox"/> Yes <input type="checkbox"/> No	Details:
Any problems with your period? <input type="checkbox"/> Yes <input type="checkbox"/> No	Details:	
Sexually active: <input type="checkbox"/> Yes <input type="checkbox"/> No	Current birth control:	Last period: / /

**PERSONAL MEDICAL HISTORY**

Please check any that apply to YOU.

<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Lung disease / Pneumonia	<input type="checkbox"/> Lupus	<input type="checkbox"/> Other (please list)
<input type="checkbox"/> Cancer	<input type="checkbox"/> Thyroid disease	
<input type="checkbox"/> Ulcer / Bowel disease	<input type="checkbox"/> Migraine headache	
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Tension headache	
<input type="checkbox"/> Heart attack / Stroke	<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Kidney stone	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Kidney infection (Pyelonephritis)	
Details:		

SURGICAL HISTORY		
Surgery	Date	Reason for surgery
	/ /	
	/ /	
	/ /	
	/ /	

FAMILY MEDICAL HISTORY	
Disease	Family member(s) affected (Paternal grandmother, maternal aunt, brother, etc.)
<input type="checkbox"/> Cancer (type)	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Thyroid disease	
<input type="checkbox"/> Heart disease	
<input type="checkbox"/> Blood clot	
<input type="checkbox"/> Other	

SOCIAL HISTORY	
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of cigarettes per day:
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of drinks per day or week:
Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please list:

MENTAL HEALTH HISTORY
Please describe any current or past mental health problems.

COMMUNICABLE DISEASES			
Disease	Date diagnosed		
<input type="checkbox"/> Gonorrhea	/ /	<input type="checkbox"/> Herpes	/ /
<input type="checkbox"/> Chlamydia	/ /	<input type="checkbox"/> Hepatitis B / C	/ /
<input type="checkbox"/> Syphilis	/ /	<input type="checkbox"/> HIV	/ /
<input type="checkbox"/> Other			/ /

REASON FOR VISIT