Patient Registration Form

Patient Name: (Last) _____ (First) _____ Middle Initial: _____

Preferred Name/Nickname: _____ Date of Birth: _____

Sex: ☐ Female ☐ Male ☐ Other Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Language: _____ Social Security #: _____-_____-_____

Race: ☐ American Indian/Native Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander

☐ White/Caucasian ☐ Choose Not to Answer

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Business Phone: _____ Email: _____

Preferred Method of Contact: ☐ Phone ☐ Cell ☐ US Mail ☐ Email

Insurance Information

Insurance Company Name: _____ Policy ID #: _____

Group #: _____

Subscribers Name: _____ Subscribers Date of Birth: _____

Relationship to Patient: _____

Subscribers Address (If different from patient): _____

Secondary Insurance

Insurance Company Name: _____ Policy ID #: _____

Group #: _____

Subscribers Name: _____ Subscribers Date of Birth: _____

Relationship to Patient: _____

Subscribers Address (If different from patient): _____

Signature: _____ Date: _____

Preferred Pharmacy

Local Pharmacy

Pharmacy Name: _____

Address: _____

Phone Number: _____

Mail Order

Pharmacy Name: _____

Address: _____

Phone Number: _____

Preferred Laboratory Service

Lab Corp ☐ Quest ☐ Shore Medical Center ☐ Other ☐

Primary Care Physician

Providers Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Advanced Beneficiary Notice of Insurance Coverage

For Preventative Medical Services

Patient Name: _____ Date: _____

What you need to know:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading.
- Choose an option below about your Preventative Medical visit.

Preventative Gynecological Services **include:** A **breast** exam to check for lumps, skin changes, or nipple discharge. A pelvic exam to check your vulva, vagina, **cervix**, uterus, rectum, and **pelvis**, including your ovaries, for masses, growths or other abnormalities, a Pap test to screen for cervical cancer, STD, STI screening and refill of any current medications if applicable.

If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventative medical visit, and if the problem or abnormality requires additional follow up and intervention, then these services will be billable in addition to your preventative gynecological services and may require a copay.

Please select from the following options in reference to your visit today:

Options: (Please check one)

☐ **Option 1:** I wish to only receive my annual visit and do not have any problems to discuss

☐ **Option 2:** I will return to a later appointment to discuss and address any problems that I may be experiencing

☐ **Option 3:** I wish to have my annual exam and also discuss any problems I am having during my annual visit. **I do understand that a copay will be applied due to this option.**

☐ **Option 4:** This is a problem visit only – **I understand I am responsible for my copay at time of visit.**

Patient Signature: _____ Date: _____

No Show/Cancellation Policy

Here at Intuitive Women's Health we want you to know that we appreciate you as a patient to our practice and value your time.

It is the policy of Intuitive Women's Health that in the event you are unable to make your appointment we require a 24 hour notice of cancellation. We understand that emergencies occur and ask that if you cannot make your appointment to please call the office immediately to reschedule. If you fail reschedule your appointment or are a NO SHOW, a $50.00 fee will be applied to your account.

By signing this form you acknowledging our cancellation/ No Show policy, and that the fees incurred due to failure to present for your appointment are your sole responsibility.

Name (**Printed**): _____

Signature: _____ Date: _____

Consent for Treatment

I acknowledge that I have elected on my own behalf or on the behalf of my dependent to receive medical services deemed necessary by the provider for my treatment and care that may or may not be covered by my health insurance or specific insurance plan. I understand that I have the right to refuse any course of treatment before services are rendered. I understand that I have the right to a second opinion by another medical professional before services are preformed but understand I am still fully responsible for any fees incurred by my office visit.

Release of Information

I authorize the release of all information necessary to carry out my treatment plan as advised by the provider, as well as to any third parties necessary to my process my insurance claims. This authorization will remain in effect until revoked by me in writing.

A photo copy of this release is to be considered as valid as the original.

Assignment of Benefits

I assign all medical and/or surgical benefit including major medical benefits to which I am entitled including but not limited to; Medicare, BCBS, HMO plans and Commercial insurance plans to **Intuitive Women's Health LLC**. This assignment will remain in effect until revoked by me in writing. I hereby authorize the above to release information to secure payment on my behalf.

Financial Responsibility

I understand and acknowledge that I am financially responsible for, and therefore shall pay for in full, ALL services rendered to me or my dependent that are not covered, that are contractually adjusted, that are not paid in full/ or paid in part by my insurance carrier.

(PLEASE CHECK BOX) ☐ I have read the above information and understand the information provided to me.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Signature of Parent or Guardian: _____

Privacy Practices and Authorizations

Contact Authorization

I authorize and give permission to Intuitive Women's Health LLC or any of the practice employees or representatives to leave a message regarding my medical information on the following forms of communication.

(Please select box that corresponds to your permissions)

Home Phone: _____ Detailed message ☐ Return Call Only ☐

Cell Phone: _____ Detailed message ☐ Return Call Only ☐

By signing this form you authorize Intuitive Women's Health LLC to send both email and mail through USPS regarding your account. We do not share information with third party vendors and your information is used solely for the purpose of patient account management i.e. (appointment reminders, billing statements, office promotions etc.)

Release of Information Authorization

I authorize and give permission to Intuitive Women's Health LLC or any of the practice employees or representatives to speak with the following person(s) regarding my patient account, medical status and/or treatment.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Acknowledgement of Receipt of Notice and Approval of Privacy Practices

I, _____ hereby acknowledge that I have received the corresponding HIPAA Notice of Privacy Practices. I also further acknowledge and approve the users and disclosures of my PHI (Personal Health Information) as described in the HIPAA Notices of Privacy Practices.

Signature: _____ Date: _____

Consent to Collection

By signing this form you agree in order to service your account and/or to collect monies owed, Intuitive Women's Health LLC and/or our agents may contact you via telephone at any number associated with your account, including wireless telephone, which could result in charges to you. We may also contact you via text messages or emails, using any email address attached to your account. Methods of contact may include, but are not limited to pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable by law.

☐ I have read this disclosure and agree to the terms associated with delinquent accounts.

Signature: _____ Date: _____

INTUITIVE Women's HEALTH

Health History Questionnaire

Patient Name: _____ Date of Birth: _____

Are you currently sexually active? ☐ YES ☐ NO

Do you use protection? ☐ YES ☐ NO

If yes: What method do you use? Please select your choice:

☐ 1. Spermicides ☐ 2. Condoms ☐ 3.Pullot Method ☐ 4. Birth Control

Do you use tobacco products? YES NO

If yes how often: _____ (amount per day)

Do you smoke marijuana? ☐ YES ☐ NO

Do you use any other drugs that are not prescribed by a physician?

If yes how often? _____

Do you drink alcohol? ☐ YES ☐ NO

If yes, how often:

☐ Socially ☐ Frequently ☐ Rarely

How old were you when you got your first period? _____

How do you describe your period? ☐ Every 28 day ☐ Every 30 days ☐ Irregular

Do you experience Pelvic pain with your period? ☐ YES ☐ NO

How would your characterize your period? ☐ HEAVY ☐ LIGHT ☐ REGULAR

How long does your period usually last? ☐ 1-14 day ☐ 4-7 days ☐ More than 7 days

Medical History

Patient Name: _____ Date: _____

Please enter corresponding date for the following questions.

Last Period? _____Last Pap Smear? _____ Las? Mammogram? _____

Are you allergic to any medications or food? YES NO

If yes please, please provide your allergy

_____

Current List of Medications:

Name	**Dose**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History:	**Date Diagnosed**	**Information**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Surgical History:

Name	Date of Surgery	Inpatient or Same Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any history of sexually transmitted diseases? YES NO

Please check all that apply

Chlamydia ☐ Gonorrhea ☐ HPV ☐ Herpes ☐ Genital Warts ☐

Any family history of the following cancers:

Breast, Ovarian, Cervical, Uterine, Prostate, Colon. ☐ YES ☐ NO

How many pregnancies have you had? _____

How many living children do you have? _____

Vaginal deliveries? _____

Caesarian Section? _____

Miscarriages? _____

Abortions? _____ ☐ Spontaneous ☐ Induced

_____ _____

Patient Signature Date: