Chesapeake Women's Care, P.A. **Patient Information**

Date _____ Social Security No. _____

Name _____ Maiden Name _____
Last *First* *M.I.*

Home Address _____ Home # _____ Cell # _____

City _____ State _____ Zip _____

Age _____ Date of Birth _____ Place of Birth _____

Race _____ Religion _____ Marital Status S W M D Separated

Occupation _____ Employer _____

Business Address _____ Work Telephone No. _____

Spouse/Primary Insured Name _____ Age _____ Telephone No. _____

Address *(if different from patient)* _____

Occupation _____ Employer _____

Business Address _____ Work Telephone No. _____

Date of Birth _____ Social Security Number _____

In emergency notify *(other than spouse)* _____

Address _____ Telephone Number _____

Relationship _____

Mother or Father's Information (if minor) Name _____

Address _____ Telephone Number _____ *(work)* _____ *(home)*

INSURANCE INFORMATION

Name of Insurance Company _____ Effective Date _____

Policy Holder's Name _____ I.D. # _____

Policy Holder's Date of Birth _____ S.S. # _____

Name Primary Care Physician _____

Reason for today's visit:

Routine GYN and Pap Smear: _____ Prenatal Care: _____ Other: _____

Consult: _____ Referring Doctor: _____ Phone: _____

NOTE: THE REASON LISTED ABOVE FOR TODAY'S VISIT WILL HELP US BILL YOUR INSURANCE COMPANY PROPERLY AND ACCURATELY. BECAUSE IT IS CONSIDERED FRAUD, WE WILL NOT CHANGE YOUR DIAGNOSIS IF YOUR INSURANCE DOES NOT COVER ANY OF THE SERVICES RENDERED TODAY. IF YOU HAVE QUESTIONS ABOUT YOUR LAB BILL, PLEASE DO NOT CALL THIS OFFICE-CALL THE LAB.

RECEIPT OF NOTICE OF PRIVACY PRACTICES Written Acknowledge ment

I, _____ have received a copy of Chesapeake Women's Care Notice of Privacy Practices.

Signature of Patient _____ Date _____

NOTICE TO ALL PATIENTS:

- I acknowledge and understand that I am responsible for the charges for all of the services rendered to me or any member of my family.
- I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Chesapeake Women's Care, P.A.
- I clearly understand that it is my responsibility to make sure the bill is paid within sixty days. If for any reason any portion of my bill is not paid by m insurance company, I further agree to make arrangements for prompt payment of the bill.
- If for any reason my insurance coverage is dropped or cancelled at any point, I hereby agree to pay promptly upon receipt of the monthly statemer
- Despite the type of insurance you have, we require your signature to keep in your file.

Signature of Patient _____ Date: _____

Chesapeake Women's Care, P.A.

NAME _____ AGE _____ DATE _____

MEDICAL HISTORY

Medications currently taking: _____

Vitamins, Herbal Supplements: _____

Medical Illnesses: _____

_____

_____

Allergies: _____

Previous surgeries or hospital admissions *(List dates & reason)* _____

_____

COLPO: _____

LEEP: _____

Have you ever had a blood transfusion? NO☐ YES☐ When? _____

PERSONAL HISTORY:

Marital Status: _____ Smoke? _____ Packs per day _____

Alcohol Consumption: _____ Caffeine Consumption: _____

Recreational Drug use: _____

Have you ever been immunized against rubella (German Measles)? _____

GYN HISTORY: _____ _____ _____

Last menstrual period (1st day): _____ Normal? Previous period: _____

Age at 1st menstrual period: _____ How frequently do they come? _____

How many days do they last? _____ Flow: Heavy Medium Light Cramps: _____

Bleeding in between periods? _____ Vaginal discharge? _____

Date of last pap smear: _____ Method of contraception: _____

Have you ever had genital herpes or venereal warts? Any Abnormal PAPs? _____

Dates: _____ Treatments: _____

OBSTETRICAL HISTORY: *Please list dates* _____

Full term delilveries: _____ _____

Stillbirths: _____ Premature Deliveries: _____

Abortions: Miscarriages:

Has any BLOOD relative ever had:	No	Yes	Who?
Breast CA	☐	☐	
Ovarian CA	☐	☐	
Other Cancer	☐	☐	
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Heart Disease	☐	☐	
Birth Defect	☐	☐	