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	☐	☐	

RELEASE OF INFORMATION:

Please tell us how you wish to be contacted. Check all that apply.

Contact Phone #:

(______) ____________________

____OK to leave message with detailed information
____Leave message with call back number/name only

___ E-Mail address ____

Please tell us with whom we are allowed to discuss and/or disclose your Personal Health Information.

Circle all that apply: Spouse Adult Children Parents Sibling Personal Representative

Name(s) of above: ________________________________ Phone: (___)__________

________________________________ Phone: (___)__________

Pharmacy Name / Location: ____

____

Pharmacy Phone #: (______) ______________________________________

____
PATIENT/RESPONSIBLE PARTY SIGNATURE

___/___/___
DATE