ALLIANCE FAMILY HEALTH CENTER

Women's Health Patient Registration

Legal Name:_____ **Date of Birth**:_____ **SS#**: ___-___-____
Preferred Name: _____ **Preferred Language:**_____
Address:_____ **City:**_____ **State:**_____ **Zip Code:** _____
Pharmacy:_____ **Email:** _____

Marital status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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

Home Phone: (_____)_____-_____ **Cell Phone:** (_____)_____-_____
Preference for appointment reminders:
Consent to call (circle): *YES* *NO* Consent to text (circle): *YES* *NO*

May we leave a message on answering machine concerning:
Results of Tests (circle): *YES* *NO* Appointments (circle): *YES* *NO*

Why do we ask lifestyle questions? Because we treat uninsured and underinsured patients, we are required to report certain demographics on **ALL** patients. Reported information will not contain your name, address, or social security number. Blank answers will be noted as declined.

Please check any which apply

Sexual orientation: ☐Heterosexual (Straight) ☐Homosexual (Gay or Lesbian) ☐Bisexual ☐Other ☐Unsure

Gender identity: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Gender Queer ☐Other

Preferred Pronoun (*Example: He, She, Him, Her, It, Etc.*): _____

Are you a veteran: ☐Yes ☐No **Are you homeless:** ☐Yes ☐No

Agricultural worker: ☐Yes ☐No **Public housing patient:** ☐Yes ☐No

What is your current family size (living in household): _____

What is your current household estimated income: $_____ (YEARLY MONTHLY BI-WEEKLY WEEKLY)

How did you hear about us? _____

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Insurance Information

Primary Insurance Name_____
Member I.D. # _____ Group #_____
Policyholder Name _____ Date of Birth _____
SS # _____-_____-_____ Policyholder Employer _____
Patient's Relationship to Policyholder (*Check one*) _____Self _____Spouse _____Dependent

Secondary Insurance Name _____
Member I.D. # _____ Group # _____
Policyholder Name _____ Date of Birth _____
SS # _____-_____-_____ Policyholder Employer (if different) _____
Patient's Relationship to Policyholder (*Check one*) _____Self _____Spouse _____Dependent

EMERGENCY CONTACT INFORMATION: Please give the name and phone number of a responsible person that you give permission for our office to contact in case of an emergency.

_____
Name Relationship Phone #

RELEASE OF INFORMATION: Please give the name and phone number of a responsible person you authorize to use, receive and/or disclose your protected health information

_____
Name Relationship Phone #

I am authorizing treatment for the above patient. This treatment may include administration of medications, diagnostic testing, and X-ray examinations, or other treatment as deemed necessary by the attending physician. I authorize the release of any medical or other information necessary to process claims on my behalf. I authorize my insurance benefits (included authorized Medicare benefits, if applicable) be paid directly to Alliance Family Health Center (AFHC) for any services furnished. To provide continuity of care, I authorize the release of medical information to specialty physicians under contract with AFHC. I understand that I am responsible for all co pays, deductibles, and co insurance. Furthermore, if I am not eligible for insurance, I am responsible for full payment of services rendered. I acknowledge that I have been notified that the Notice of Privacy Practices of AFHC, which sets forth the ways in which my protected health information may be used or disclosed by AFHC, and outlines my rights with respect to such information. I have been provided the opportunity to request a paper copy of this notice as well as information on how to view the notice electronically on the website at www.alliancefamilyhealth.org. I give permission for AFHC Physicians to obtain my medication history, benefits, and formulary information from my pharmacy on file.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Date Relationship if not signed by patient

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PATIENT'S PAST MEDICAL HISTORY

Please check yes to each which apply to patient:

	Yes		Yes		Yes
Acid Reflux (GERD)		Breast problems		Kidney disease	
Addiction		Cancer		Liver disease	
ADHD		Coronary Artery Disease (CAD)		Lung disease	
AIDS/HIV		Depression		Mental or emotional problems	
Anemia		Diabetes		Mental, physical or verbal abuse	
Anxiety		Eating disorder		Muscle, joint or bone problem	
Asthma		GI problems		Osteoporosis	
Autoimmune disease		Headache/Migraines		Seizures/epilepsy	
Birth defect or inherited disease		Heart problems		Skin problems	
Bladder problems		Hepatitis		Thyroid problems	
Bleeding disorder		High blood pressure		Tuberculosis	
Blood transfusions		High cholesterol		Vision/Eye problems	
OTHER					

Has the patient ever had any surgeries or hospitalizations? ☐YES ☐NO

If yes, please list with year: _____

_____

Does the patient have any allergies to medications, substances, or food? ☐YES ☐NO

If yes, please list all allergies: _____

CURRENT MEDICATIONS

Medication Name	Dose	Who prescribed medication (*Provider or Specialty*)

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FAMILY MEDICAL HISTORY

Please list any immediate family medical history

(*example: Cancer, Diabetes, Hypertension*)

	Medical History		Medical History
Mother		Father	
Sibling(s)		Child	
Maternal Grandmother		Paternal Grandmother	
Maternal Grandfather		Paternal Grandfather	
Maternal Aunt(s)		Paternal Aunt(s)	
Maternal Uncle(s)		Paternal Uncle(s)	

HEALTH HABITS

Does the patient use tobacco products? ☐ YES ☐ NO *If yes, how much per day?* _____

Does the patient drink alcohol? ☐ YES ☐ NO *If yes, how many drinks per week?*_____

Does the patient use any illegal substance? ☐ YES ☐ NO *If yes, what kind and frequency* _____

OBSTETRIC HISTORY

Is patient currently pregnant? ☐ YES ☐ NO *If yes,what is date of last period?*_____

	NUMBER		**NUMBER**
Preterm births (*less than 36 weeks*)		Abortions	
Miscarriage or Ectopic/Tubal pregnancy		Living children	
Full term births		Total number of pregnancies	

PAST DELIVERIES

Below list all past delivery details

Date of Birth	Gest. Age (Weeks)	Labor Length (hours)	Baby's Weight	Baby's Sex (M/F)	Delivery Type (Vaginal, C-Section, VBAC)	Complications	Location of Delivery

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GYN AND SEXUAL HISTORY

Patient's age at first period? _____ **How many days does period last?** _____days

Flow: ☐Light ☐Medium ☐Heavy **How long from start of period to start of next period?** _____ days

Number of tampons per day: _____ **Number of pads per day:** _____

Does patient have clots? ☐YES ☐NO **Cramps?** ☐YES ☐NO **Pain?** ☐YES ☐NO

Does patient bleed when it is not their period? ☐YES ☐NO **Any problems with infertility?** ☐YES ☐NO

Is patient currently sexually active? ☐YES ☐NO **Does patient have sex with:** ☐Men ☐Women ☐Both

Lifetime sexual partners: ☐Less than 5 ☐More than 5 **New sexual partner?** ☐YES ☐NO

Has patient ever had a sexually transmitted disease? ☐YES ☐NO

When was patient's last Pap? ____/____/_____ **Has patient had any abnormal Pap result?** ☐YES ☐NO

Where was last Pap performed?_____ (Location or Physician)

Has the patient ever had a procedure on cervix? (colposcopy or LEEP) ☐YES ☐NO

Has the patient received the HPV vaccine? ☐YES ☐NO

Date of last mammogram: ____/____/_____ Were results normal? ☐YES ☐NO

Date of last bone density scan: ____/____/_____ Were results normal? ☐YES ☐NO

Has patient gone through menopause? ☐YES ☐NO If yes, at what age?_____

Has patient had any vaginal bleeding since menopause? ☐YES ☐NO

Is patient on hormone replacement therapy? ☐YES ☐NO

If patient was born between 1938 and 1971, did mother take DES while pregnant? ☐YES ☐NO

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