Getting to know you!

What goals do you have for your body or health?

What do you value the most from your doctor or clinician?

What is the reason for your visit?

○ Pregnancy ○ Annual Exam ○ Other
○ Medical Problem ○ New to Area ____________________

How did you hear about us? (mark all that apply)

○ **FRIEND/FAMILY** (please print their name clearly so we may send them a Thank You card.

____

INTERNET

○ Google ○ Yelp ○ Google Plus
○ Facebook ○ Pinterest ○ Other
○ YouTube ○ Twitter
○ Patch Blog

OTHER

○ Physician/Provider referral ○ Hospital ○ Insurance
○ Dr. Litrel's Articles ○ Magazine/Newspaper Advertisement ○ Which magazine?

E-NEWSLETTER

Would you like to subscribe to Cherokee Women's Health Specialists e-newsletter? You'll receive articles, fun shares, contest info and up-to-date solutions for women's health. (please circle one)

Yes No Email: ____________________________________

Patient Name: ______________________________ Date: __________

Date of Birth: ____________

File Name and Path: C:\Users\diane.warren\Desktop\New folder\GET KNOW YOU SURVEY (PRINT) DONE.docx
Updated: 7/2/14
Staff directions: This completed form is collected by check-in and routed to Division 6

PATIENT REGISTRATION FORM

Name (Last, First, Middle):	Date of Birth:
Maiden Name:	Marital Status S M D W
Address: Street: City, State, Zip:	Home Ph #: Cell Ph #: Work Ph #:
Employer/Occupation:	Email:
Spouse/Parent/Guardian:	Ph #:
Emergency Contact:	Relationship:
Emergency Contact Ph #:	
Insurance Information	
Primary Insurance	
Name of Insured:	Insured's Date of Birth:
Relation to Insured (circle one): Self Spouse Child	
Secondary Insurance	
Name of Insured:	Insured's Date of Birth:
Relation to Insured (circle one): Self Spouse Child	

PROVIDE COPY OF YOUR INSURANCE CARD

*** Payment is Due at Time of Service***

Assignment and Release: I assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to Cherokee Women's Health Specialists, PC. I understand that I am fully responsible for all charges not paid by insurance. I hereby authorize this practice to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submission. **I understand that any lab work performed will be billed directly to me by that lab**. This assignment will remain in effect until revoked by me in writing. I consent to the taking of photographic images for treatment purposes only as ordered by attending physicians.

Patient Signature: ______________________________ Date: ____________

File Name and Path: C:\Users\diane.warren\Desktop\New folder\Patient registration-DONE.docx
Updated: 6/25/14
Staff Directions: Route to Scan Bin

PLEASE ANSWER ALL QUESTIONS TO BE SEEN TODAY BY YOUR PROVIDER.

WARNING: If you want your friend or family member present during your visit today, you must know that your doctor or medical assistant will be asking you highly personal and confidential medical questions that you may not be comfortable answering in the presence of others.

NEW PATIENT MEDICAL HISTORY

Patient Name: ____

Date of Birth: ____________________

Last Menstrual Period Date: __________________

Briefly state your reason for visit: ____

____

ALLERGIES/REACTIONS: Please list any drug, food or environmental allergies and your reaction	

FAMILY HISTORY: Please list any family medical history, i.e., heart disease, diabetes, cancer, etc.			
Disease	Family Member	Disease	Family Member

PATIENT'S MEDICAL HISTORY:	
Date of last pap:	Abormal (circle one): Yes No
History of abnormal pap (circle one): Yes No	If yes, list treatment
Date of last mammo:	Abormal (circle one): Yes No
History of abnormal mammo: (circle one):: Yes No	If yes, list treatment
Date of last bone density:	Abormal (circle one): Yes No

Staff Directions: New Patient Medical History to MA. MA enters into EMR. MA Shreds.

MEDICAL HISTORY MUST BE COMPLETED BEFORE YOU CAN BE SEEN. PLEASE ANSWER ALL QUESTIONS.

GYN HISTORY:		
Age period began:	# of days between periods:	
Flow/duration of period:	Painful periods (circle one): Yes No	
Age menopause began:	Painful intercourse (circle one): Yes No	
Do you ever experience leaking of urine? (circle one): Yes No		
Blood transfusion (circle one): Yes No		
List Past GYN Problems:	List Other Medical Problems:	List Surgeries:

PREGNANCY HISTORY:		
# of pregnancies:	# of abortion(s)/miscarriage(s):	# of living children:

PREGNANCY DETAILS:					
	1st Pregnancy	2nd Pregnancy	3rd Pregnancy	4th Pregnancy	5th Pregnancy
Date					
GA Weeks					
Complications					
Delivery Type					
Length of Labor					
Birth Weight					
Sex					
Analgesia/ Anesthesia					
Treatment of Preterm Labor					
Induction					
Laceration/ Episiotomy					
Place of Delivery					

Staff Directions: New Patient Medical History to MA. MA enters into EMR. MA Shreds.

MEDICAL HISTORY MUST BE COMPLETED BEFORE YOU CAN BE SEEN. PLEASE ANSWER ALL QUESTIONS.

SOCIAL DETAILS:			
Marital Status (circle one) M S D W			
Primary Occupation:			
Primary Birth Control Method:			
Are you sexually active? (circle one): Yes No			
Do you exercise? (circle one): Yes No		Days per week:	
Tobacco Use? Yes No	Alcohol Use? Yes No	Drug Use? Yes No	Caffeine Use? Yes No
Amount:	Amount:	Amount:	Amount:
Medications: Please list any medications the patient is currently taking.			
Medication Name	Strength/Dose	Medication Name	Strength/Dose

PHARMACY INFORMATION:		
Name	Location	Ph #:

Staff Directions: New Patient Medical History to MA. MA enters into EMR. MA Shreds.