Seattle Women's
HEALTH • RESEARCH • GYNECOLOGY

Lakeview Medical Dental Building
3216 NE 45th Place, Suite 100
Seattle, WA 98105

Phone: 206-522-3330
Fax: 206-522-8594
www.SeattleWomens.com

HEALTH AND GYNECOLOGY REGISTRATION FORM

PATIENT:_____ DOB:_____ AGE:____ DATE: _____
Last Name First Name M.I.

ADDRESS: _____ CITY:_____ STATE:_____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ MOBILE: _____

Please indicate whether it is OK to leave a detailed message on your voice mail at the above number(s): ☐ Yes ☐ No

EMAIL ADDRESS (IF WE MAY USE IT TO CONTACT YOU): _____

We may occasionally contact you to ask if you would like to participate in a women's health research study in this office. If you would like to opt out of this opportunity, please check here: ☐

REFERRED BY: _____ FAMILY DOCTOR: _____

PATIENT INFORMATION

MARITAL STATUS (CIRCLE ONE): Single Married Partnered Widowed Separated Divorced GENDER: M / F
SOCIAL SECURITY #:_____ OCCUPATION:_____
EMPLOYER:_____
ARE YOU A FULL TIME STUDENT?: Y / N IF YES: SCHOOL:_____

SPOUSE INFORMATION

SPOUSE'S NAME:_____ DOB: _____
SPOUSE'S EMPLOYER:_____ OCCUPATION:_____
WORK PHONE:_____

PERSON RESPONSIBLE FOR BILL IF *NOT* THE PATIENT

NAME:_____ RELATIONSHIP TO PATIENT:_____
ADDRESS:_____ CITY:_____STATE:_____ZIP:_____
EMPLOYER:_____ DAYTIME PHONE #:_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SECONDARY INS: _____
SUBSCRIBER NAME :_____ SUBSCRIBER NAME: _____
SUBSCRIBER DOB: _____ SUBSCRIBER DOB: _____
GROUP #: _____ GROUP #: _____
MEMBER #: _____ MEMBER#: _____
PATIENT RELATION TO SUBSCRIBER: _____ PATIENT RELATIONSHIP TO SUBSCRIBER: _____
SUBSCRIBER EMPLOYER: _____ SUBSCRIBER EMPLOYER: _____

In Case of Emergency - Person to Be Notified *(Not at same address)*

NAME: _____ RELATIONSHIP TO PATIENT: _____
HOME PHONE: _____ WORK PHONE: _____

ASSIGNMENT AND RELEASE: *I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I ALSO AUTHORIZE THE DOCTOR OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED FOR THIS CLAIM. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE.*

PATIENT SIGNATURE: _____ **DATE:** _____

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Dear Patient,

When you schedule your appointment at Seattle Women's, it is important to specify the type of care you are requesting so that we can allow the appropriate amount of time for your visit and ensure the services you receive are billed accurately to you and your insurance carrier.

Below is an explanation of the different categories of care as defined by insurance carriers. Not all types of care are reimbursed by insurance plans. Please check with your insurance carrier before your visit so that you are aware of your level of benefits.

Preventive Care (also known as Routine, Annual, Yearly or Well-Woman Exam): "Preventive" care includes a comprehensive history, a comprehensive examination and ordering of appropriate lab and diagnostic tests. **An appointment for "preventive" care does not include treatment for acute, recent or chronic problems.** Some examples of care *not included* in a preventive exam are: vaginal infections, abdominal pain, menstrual problems and peri-menopausal or menopausal issues. In order to provide you with the best care possible, a separate appointment is required for treatment of acute, recent or chronic illness, such as, but not limited to the problems above.

We believe having your annual "preventive" care exam is important, however insurance coverage for this service varies considerably. Some plans cover "preventive" services at 100%, some cover only a certain amount per plan year and some do not provide any coverage. In that case, the patient is responsible for the entire balance including any laboratory charges. Please confirm your plan benefits for "preventive" care prior to your appointment. If you are scheduled for a "preventive" exam, our office will bill your insurance for "preventive" care. Once billed with a "preventive" diagnosis code, the service cannot be rebilled using any other diagnosis.

Office Visit: Evaluation and/or treatment of a specific problem or problems. If you have more than one problem, please let the receptionist know so that adequate time is allowed for your visit.

When calling to schedule your appointment, please let our receptionist know the type of exam you are requesting, as this will affect the amount of time scheduled and how the service is billed. Please return this form to our office prior to your appointment. If you have questions prior to completion of this form, please let us know and one of our staff will be happy to assist you.

I understand that I have requested a:

☐ Preventive Care Exam ☐ Office Visit

I understand that it is my responsibility to check with my insurance company, prior to my appointment, regarding coverage of the above service. If the above service is not covered by my insurance, I am responsible for the bill, which may include any lab work done. I also understand that the service code and diagnosis cannot be changed after the original bill has been submitted.

_____

Patient Signature Print Name Date

Seattle Women's: Health, Research, Gynecology ® is dedicated to providing exemplary health care for women of all ages. We offer a unique practice that integrates preventative care and medical treatment in addition to cutting-edge research. Our approach creates a standard of excellence in the specialized care of women

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INTAKE FORM

Please use black or blue ink & do NOT print double-sided

NAME _____ **DOB**_____ **AGE** ___ **DATE**___ /___ /___
First MI Last

How would you like to be addressed? _____
Gender: Female☐ Male☐

Primary Care
Name Address Telephone number

Pharmacy
Name Address Telephone number

Reason for visit: _____

If the reason for your visit is a STUDY, please initial the following statement:
____ I am currently *not* participating in any other clinical trials at other locations

MEDICAL HISTORY AND REVIEW OF SYMPTOMS

Condition	When?	Date First Diagnosed	Date Resolved	Taking Medication?	Office Use Only
Dermatological (Skin)	**None ☐**				
Precancer/Cancer	Now ☐ In the past ☐				
Rash	Now ☐ In the past ☐				
Abnormal mole	Now ☐ In the past ☐				
Other skin conditions: _____	Now ☐ In the past ☐				
Neurological (Nervous system)	**None ☐**				
Migraines / Headaches	Now ☐ In the past ☐				
Depression	Now ☐ In the past ☐				
Anxiety	Now ☐ In the past ☐				
Psychiatric Care/ Hospitalization	Now ☐ In the past ☐				
Epilepsy/Seizures	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Cardiovascular (Heart & blood)	**None ☐**				
Heart Murmur	Now ☐ In the past ☐				
Irregular Heart Rate/Palpitations	Now ☐ In the past ☐				
Chest Pain	Now ☐ In the past ☐				
Heart Attack	Now ☐ In the past ☐				
High Blood Pressure	Now ☐ In the past ☐				
Elevated Cholesterol	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Pulmonary (Lungs)	**None ☐**				
Asthma	Now ☐ In the past ☐				
COPD	Now ☐ In the past ☐				

Persistent Cough	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Gastrointestinal (Digestion)	**None ☐**				
Ulcers	Now ☐ In the past ☐				
Hepatitis / Liver Problems	Now ☐ In the past ☐				
Gall Bladder Disease	Now ☐ In the past ☐				
Heartburn/GERD	Now ☐ In the past ☐				
Chronic Constipation	Now ☐ In the past ☐				
Diarrhea	Now ☐ In the past ☐				
Persistent Nausea ☐ Vomiting ☐	Now ☐ In the past ☐				
Blood in Stool	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Urologic (Kidneys & Bladder)	**None ☐**				
Frequent Urinary Tract Infection	Now ☐ In the past ☐				
Kidney Infection	Now ☐ In the past ☐				
Kidney Disease	Now ☐ In the past ☐				
Bladder Problems Incontinence (leaking) Urinary Frequency Urinary Urgency	 Now ☐ In the past ☐ Now ☐ In the past ☐ Now ☐ In the past ☐				
Blood in Urine	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Musculoskeletal(Muscles& Bones)	**None ☐**				
Osteoporosis ☐ Osteopenia ☐	Now ☐ In the past ☐				
Arthritis: Type_____	Now ☐ In the past ☐				
Fibromyalgia	Now ☐ In the past ☐				
Fractures	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Eyes, Ear, Nose, Throat	**None ☐**				
Glaucoma -Type _____	Now ☐ In the past ☐				
Hearing Problems	Now ☐ In the past ☐				
Seasonal Allergies/Hay Fever	Now ☐ In the past ☐				
Cataracts	Now ☐ In the past ☐				
Other eye problems: _____	Now ☐ In the past ☐				
Current dental issues?	Yes ☐ No ☐				
Other:_____	Now ☐ In the past ☐				
Endocrine (Glands)	**None ☐**				
Diabetes Mellitus: Type I or II	Now ☐ In the past ☐				
Thyroid Disease	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Hematology (Blood Disorders)	**None ☐**				
Anemia	Now ☐ In the past ☐				
Blood Clots / Pulmonary Embolism	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Lupus/ SLE	Now ☐ In the past ☐				
Cancer	**None ☐**				
Cancer Type:_____	Now ☐ In the past ☐				
Cancer Type:_____	Now ☐ In the past ☐				
Cancer Type:_____	Now ☐ In the past ☐				
Cancer Type:_____	Now ☐ In the past ☐				

SURGICAL HISTORY (Including Cosmetic Surgery)

Surgery type	Date(s)	Reason	Where was it done (Hospital/City)?

FAMILY MEDICAL HISTORY

Relative	Living?	Major Medical Problems (i.e. stroke, heart attack)
Mother		
Father		
Siblings		
Siblings		
Siblings		
Other		

CURRENT MEDICATIONS

Medications you are taking currently (include those you buy at the drug store, health food store)					
Medications, Vitamins, and/or Health supplements	**Dose** (e.g. 10mg)	**How often?** (e.g. twice a day)	**Start Date**	**Stop Date** (If applicable)	**Reason taken** (e.g. cholesterol)
Other Medications you have taken in the past 3 months					

MEDICATION(DRUG) / FOOD ALLERGIES

Medication or Food	Reaction	Date you first had this reaction

PERSONAL HEALTH HABITS

Occupation:_____ Single☐ Partnered☐ Married☐ Widowed☐ Divorced☐ Separated☐
Tobacco use? How much per day? _____ Year started_____ Year quit _____
Alcohol use? YES ☐ NO ☐ Average number of drinks per week _____
Current or past history of substance abuse? YES ☐ NO ☐ Dates:_____
Do you exercise? _____ How often? _____ Any dietary restrictions? _____

IMMUNIZATIONS

Yearly flu shot? YES ☐ NO ☐ Date of last tetanus shot _____ (recommended every 10 years)
Have you had a Measles/Mumps/Rubella vaccine? YES ☐ NO ☐ Have you had a varicella vaccine (or had chicken pox)? YES☐ NO☐
If age 65 or over, have you had a pneumococcal vaccine? YES ☐ NO ☐
Ever been tested for Tb? YES☐ NO☐ Was it positive? YES ☐ NO ☐ BCG Vaccine YES ☐ NO ☐
Have you had the series of vaccines for HPV (Human Papilloma Virus)? YES ☐ NO ☐ I've had: All three vaccines ☐ The first one only☐ Two vaccines☐

FEMALES: OBSTETRIC HISTORY (PREGNANCY)

Date	Type of Delivery	Complications of pregnancy

OTHER PREGNANCIES- MISCARRAGES/ ABORTIONS/ ECTOPICS

Date	Outcome

GYNECOLOGICAL HISTORY

Last Menstrual Period:	Method of Birth Control:
Age of 1st menstrual period:	
Menses last_____ days and come every _____ days :	_____heavy _____medium _____light
Last Pap:	If any abnormal paps, when and how was it treated:
Last mammogram:	Where:
Any abnormal mammograms and when:	
Breast procedures/ Ultrasound/ MRI?	
Breast Implants? Type:	
Lifetime sexual partners _____ 1-5 _____ 6-20 _____ > 20	

Condition	When?	Date First Diagnosed	Date Resolved	Taking Medication?	Office Use Only
Genital Infections: ☐ Bacterial Vaginosis ☐ Gonorrhea ☐ HPV ☐ Chlamydia ☐ Herpes ☐ Other:_____					
Uterine fibroids	Now ☐ In the past ☐				
Ovarian Cyst	Now ☐ In the past ☐				
Vaginal Dryness	Now ☐ In the past ☐				
Decreased Sex Drive	Now ☐ In the past ☐				
Painful intercourse	Now ☐ In the past ☐				
Irregular Bleeding	Now ☐ In the past ☐				
Painful Periods	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				

MALES:

Condition	When?	Date First Diagnosed	Date Resolved	Taking Medication?	Office Use Only
Reproductive	**None ☐**				
Genital Infections: ☐ Bacterial Vaginosis ☐ Gonorrhea ☐ HPV ☐ Chlamydia ☐ Herpes ☐ Other:_____					
Prostate Problems	Now ☐ In the past ☐				
Decreased Sex Drive	Now ☐ In the past ☐				
Erectile Dysfunction	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				

Patient Signature _____ Date _____

Reviewed by **Provider:** _____ Date _____

Reviewed by **CRC** (*if applicable*) _____ Date _____