CENTER FOR WOMEN'S CARE
BARBARA A. SOLTES,M.D.

NAME:______________________ AGE:________ TODAYS DATE:__________________

ADDRESS:__________________ PHONE (HOME):______________________________

__________________ PHONE (WORK):______________________________

RACE:______________________ HEIGHT:__________ WEIGHT:__________________

DATE OF BIRTH:______________ SOCIAL SECURITY #:_________________________

PRESENT COMPLAINT: ____

____

<u>MEDICAL HISTORY</u>:

Have you ever had any of the following conditions or diseases? *(please check all that apply)*

__Allergies	__Heart disease	__Psychiatric disorder	__Urinary problems
__Hypertension	__Kidney disease	__Phlebitis	__High cholesterol
__Injuries	__Thyroid disease	__Cancer	__Skin Conditions
__Liver disease	__Epilepsy/Neurological disease	__Diabetes	__Eye Disorders
__Lung disease	__Congenital disease	__Blood Transfusion	__Gall Bladder
__Musculoskeletal	__Hormone Problems	__Intestinal Problems	__Ears, Nose, Throat
__Blood/Lymphatic	__Bone disease	__Breast Problems	

Please describe all of the medical conditions checked above and list any other medical diseases/ illnesses:____

____

____

Allergies to medications (list all):

____

Last Mammogram________Last Dexa Scan________Last Colonoscopy_________

GYNECOLOGICAL HISTORY:

Menarche (your age at the start of first menstrual period):_______________________________

If Menopausal, age of your last period:_______________________________________

Bleeding Frequency (approximate length between menstrual periods):

____

How many days does it last?____ Do you have Painful Periods?_________________________

Date of Last TWO Menstrual Periods (1st day started period) ____/____/____; ____/____/___

Do you experience irregular bleeding or irregular periods: _____YES ______NO

Date of most recent pap smear: ___/___/___ Have you ever had an abnormal Pap Smear? __YES __NO

Have you ever had an abnormal pelvic exam? __YES __NO

Do you have a history of : __Herpes __Venereal Diseases (Syphilis, Gonorrhea, Chlamydia)

Pregnancies: List all pregnancies, giving dates, outcome, weight, sex, complications, etc.

____

____

BIRTH CONTROL EVER USED: (Please Circle)

Oral Contraceptive
IUD
Foam Cream, Suppositories
Diaphragm
Other

HORMONE REPLACEMENT THERAPY: (Please Circle)

Estrogen Dose_______________________
Progesterone Daily or Cyclic_________________
Testosterone

ALTERNATIVE THERAPY:(Please Circle)

Herbs Biofeedback Acupuncture Other

SURGICAL HISTORY:

Please list all surgeries / operations and approximate dates: ____________________________________

____

SOCIAL HISTORY:

Do you smoke? __ YES __NO If yes , please describe current smoking habits
(# of cigarettes per day)_______ (months/years)______________________

Do you drink alcohol? __YES __NO If yes, please describe current drinking habits:
(# of drinks per day or week) (months/years)______________________

Have you ever been treated for drug or alcohol abuse? __YES __NO If yes, please describe:____

FAMILY HISTORY:
Has there been any of the following diseases / illnesses in your family?

__Diabetes __Early deaths __Ovarian Cysts
__Heart Disease __Recurrent miscarriages __Muscular Dystrophy
__Hypertension __Kidney Disease __Cancer
__Endometriosis __Sickle Cell Anemia __Psychiatric/Emotional Problems
__Menstrual Problems __Abnormal Genitalia __Infertility
__Children born with birth defects, mental retardation, or other congenital abnormalities

If the answer is yes to any of the above, please explain:____

____

____

Any other problems or questions you would like to address at this appointment?______________________

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BARBARA A. SOLTES, M.D., S.C.
Center for Women's Care

PATIENT REGISTRATION INFORMATION: Date________________________

Name______________________________SSN____________________DOB__________

Address____Home Phone______________

City/State____________________________Zip Code________ Cell Phone______________

Marital Status: Single Married Divorced Widowed Separated Minor Child

Who referred you to our office?

____

In case of an emergency who should we notify? ____________________________ Phone #____________

PRIMARY INSURANCE INFORMATION

INSURED'S NAME__________________________ Relationship to Patient ______________

Insured's Date of Birth ______________Insured's Social Security #______________________

Insured's Address ____________________City & Zip ______________________________

CREDIT CARD INFORMATION Please fill in one

VISA #______________________________ V-Code _ _ _ Exp .Date______________

MASTERCARD# ________________________ V-Code _ _ _ Exp Date______________

Cardholders Name: ______________________

Address: ________________City & Zip____________________

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges whether or not paid by insurance for all services rendered on my behalf or my dependants. I authorize Dr. Soltes/Center for Women's Care to release any information required to secure the payment of benefits.

Signature of Responsible Party________________________________Date______________

AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A: Must be completed for all authorizations.

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name: ______________________ Date of Birth: ______________________

Person(s)/organizations authorized to use/disclose information (from): ______________________

____

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____

Person(s)/organizations authorized to receive the information: ______________________

____

____

____

Information that may be used/disclosed:
(Include dates where appropriate, e.g., medications dispensed in December 2002 or EKG Report performed in June 2000)

- ☐ Record of Visits (all) ______________________
- ☐ Record of Visit(s) (Specific) ______________________
- ☐ Discharge Summary ______________________
- ☐ History/Physical ______________________
- ☐ Consultation Report(s) ______________________
- ☐ Operative Report(s) ______________________
- ☐ Problem List ______________________
- ☐ Progress Notes ______________________
- ☐ Immunization Record(s) ______________________
- ☐ Medication Record(s) ______________________
- ☐ Laboratory Report(s) ______________________
- ☐ X-Ray, MRI, CT ______________________
- ☐ Echo, Stress Tests, Holters ______________________
- ☐ EKG Report ______________________
- ☐ Mental Health/Alcohol/Drug Abuse Treatment ______________________
- ☐ AIDS or HIV Information ______________________
- ☐ Hepatitis Information ______________________
- ☐ Entire Medical Record ______________________
- ☐ Statement of Charges/Payments ______________________
- ☐ Other ______________________

SECTION B: Must be completed only if a health provider or a health plan has requested the authorization.

1. The health plan or health care provider must complete the following:

   a. The information will be used/disclosed for the following purposes:

   - ☐ Continued Patient Care
   - ☐ Disability Determination
   - ☐ Personal Use
   - ☐ Attorney/Legal
   - ☐ Insurance Claim
   - ☐ Other ______________________

   b. Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes ________ No ________

2. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

3. I understand that I may inspect and copy any information to be used or disclosed.

SECTION C: Must be completed for all authorizations.

1. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires ______________________
   (Insert applicable date or event that triggers expiration)

2. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

____
Signature of Patient or Representative

____
Today's Date

____
Printed Name of Patient's Representative (if applicable)

____
Relationship to Patient