# WOMAN CARE OF RALEIGH
# PATIENT REGISTRATION

Name: First________________________ MI___ Last___________________ Date of Birth____________
Social Security #_____________________ Marital Status (**circle**) Single Married Separated Divorced Widowed
Address:________________________________City__________________________State_____Zip________
Phone:(home)________________________ (work) _____________________ (cell)________________
Email address: __________________________________________________ Best # to reach you: ____________

Employer's Name: ____________________________________________________________________________
Employer's Address:________________________________City________________State_______Zip________
Primary Care Physician's Name ______________________________ Phone ____________________
Pharmacy ______________________________________ Phone __________________________

**BILLING** (if different from above)
Name: First________________________ MI___ Last___________________ Date of Birth____________
Address:_____________________________ City:__________________________ State_____ Zip:___________
Phone: (home)__________________________ (work) _____________________________

**PRIMARY INSURANCE COMPANY**:______________________________________________________________
Policyholder's Name: First___________________________ MI___ Last________________________________
Date of Birth____________ Social Security #________________Relationship (circle) Self Spouse Parent
Address(if different):_______________________________ City______________ State_____ Zip___________
Employer Name________________________________________________ Phone________________________

**SECONDARY INSURANCE COMPANY**:_________________________________________________________
Policyholder's Name: First___________________________ MI___ Last________________________________
Date of Birth____________ Social Security #________________Relationship (circle) Self Spouse Parent
Address(if different): ________________________________City______________ State_____ Zip___________
Employer Name________________________________________________ Phone________________________

**SPOUSE/ PARENT IF MINOR** (if not listed above)
Name: First________________________ MI___ Last___________________ Date of Birth____________
Social Security #________________________Relationship (circle) Spouse Parent
Address:_____________________________ City__________________________ State_____ Zip___________
Employer Name________________________________________________ Phone________________________

EMERGENCY CONTACT
Name: First________________________ MI___ Last___________________ Date of Birth____________
Address:_____________________________ City__________________________ State_____ Zip___________
Phone: (home)__________________________ (work) _____________________________
Nearest Relative (not living with you)
Name: First________________________ MI___ Last___________________ Date of Birth____________
Phone: (home)_____________________ (work) __________________________________

**INSURANCE AUTHORIZATION AND ASSIGNMENT**: I hereby authorize Woman Care of Raleigh, PA to furnish information to insurance carriers concerning my illness/treatments and I hereby assign Woman Care of Raleigh, PA all payments for medical services rendered to myself. I understand that I am financially responsible for all charges whether or not covered by insurance.

**SIGNATURE:**_______________________________________ **DATE:**______________________

# WOMAN CARE OF RALEIGH
# HISTORY AND PHYSICAL RECORD

DATE: _______________

Name: ____________________________________________ Age: _____ Date of Birth: _________________

Reason for Visit/ Special Concerns: ____________________________________________________________________

| PAST MEDICAL HISTORY: | YES | NO | REMARKS |
|---|---|---|---|
| Childhood Illnesses/ Surgeries | ___ | ___ | _________________________________ |
| Asthma | ___ | ___ | _________________________________ |
| Bleeding Disorders | ___ | ___ | _________________________________ |
| Epilepsy | ___ | ___ | _________________________________ |
| Mental Illness/ Depression | ___ | ___ | _________________________________ |
| Hepatitis or Jaundice | ___ | ___ | _________________________________ |
| Diabetes | ___ | ___ | _________________________________ |
| High Blood Pressure | ___ | ___ | _________________________________ |
| Thyroid Disease | ___ | ___ | _________________________________ |
| Phlebitis | ___ | ___ | _________________________________ |
| Kidney Disease/ Cystitis | ___ | ___ | _________________________________ |
| Gall Bladder Disease | ___ | ___ | _________________________________ |
| Abnormal Pap Smears | ___ | ___ | _________________________________ |
| Other: _________________ | ___ | ___ | _________________________________ |

Medications: ____________________________________________________________________________________________
Vitamins/Herbs/Supplements: _____________________________________________________________________________
Allergies: ______________________________________________________________________________________________
Last Pap Smear: When _____________________ Where ___________________________ Normal? __________________
Last Mammogram: When_________________ Where__________________________________________________
Last Bone Density: When_________________ Where__________________________________________________
Operations (dates & types): ________________________________________________________________________
Smoking: ________ How much? _________ Alcohol: ________ How much? ___________
Recreational Drug Use: ________ Exercise: ________ How much? _________

**MENSTRUAL HISTORY**
First day of last menstrual period: _______________ How many days do your periods last? ______________
Periods are usually: ____ heavy ____ average ____ light Frequency of periods: ___________________
Do you have spotting or bleeding between periods? _______ Do you have spotting or pain during intercourse? _________
What type of contraception are you currently using? ____________________________________________________________

**PREVIOUS PREGNANCIES**
Total: ____________________ Live Births: __________________
Complications: ________________________________________________________________________________________

| FAMILY HISTORY: | YES | NO | REMARKS |
|---|---|---|---|
| Heart Attacks | ___ | ___ | _________________________________ |
| High Blood Pressure/ Stroke | ___ | ___ | _________________________________ |
| Diabetes | ___ | ___ | _________________________________ |
| Kidney Disease | ___ | ___ | _________________________________ |
| Cancer | ___ | ___ | _________________________________ |
| Osteoporosis | ___ | ___ | _________________________________ |

**Signature**: ___________________________________________________

# WOMAN CARE OF RALEIGH
# OFFICE PAYMENT/CANCELLATION POLICY

As part of our sincere desire to offer excellent medical care to you, and to establish and maintain a long professional and pleasant relationship, we would like to present our office payment policy in order to minimize misunderstandings about fees. We ask for payment when services are rendered. This includes payment for the office visit and any tests that are performed. We accept cash, Master Card, Visa, Discover or a personal check. If you have a medical insurance that we are contracted with (see below), we will accept the appropriate co-pay after any deductibles are met. If you are filing for your own insurance, you can send the yellow copy of your itemized statement to your carrier for processing.

Surgical fees will be filed with your insurance company. Prior to surgery we will assist you in determining your portion of the bill which is to be paid by you. Elective surgery and/or non covered surgery must be paid in full before the procedure is performed. The responsibility for payment remains solely with you, the patient. If you do not have insurance we will gladly discuss methods of payment with you.

We participate in and file for the following insurance plans:

AETNA PPO (not HMO)
BCBS (all plans)
CIGNA
UNITED HEALTHCARE
MEDCOST administered plans

We do NOT accept Medicare or Medicaid.

**Cancellation Policy: We ask that you give 24 hours notice if you are unable to keep your appointment, otherwise you will be billed a $50.00 office visit fee.**

**Prescription Refill Policy:** *All* **prescriptions provided at** *any* **time outside of a regular office visit, will incur a $10.00 processing fee.**

** I certify that I understand and agree to the above policies.

Patient Signature_____________________________________________ Date_____________

## ACKNOWLEDGEMENT OF AVAILABILITY FOR REVIEW OF THE WOMAN CARE OF RALEIGH, PA NOTICE OF PRIVACY PRACTICES

The Patient hereby acknowledges the availability of the Woman Care of Raleigh, PA Notice of Privacy Practices for her/his review. The Patient also acknowledges that a copy of the Notice of Privacy Practices was supplied to her/him if so requested.

Date: _______________

Signature of Patient: __________________________________________

Please Print Name: __________________________________________

## WOMAN CARE OF RALEIGH
## RECORDS RELEASE:

I ________________________________, REQUEST THAT MY MEDICAL RECORDS BE TRANSFERRED TO:

WOMAN CARE OF RALEIGH, P.A.
1100 DRESSER COURT
SUITE 200
RALEIGH, NC 27609
FAX # (919)850-2540

MY MEDICAL RECORDS ARE CURRENTLY WITH THE FOLLOWING PRACTICE:

________________________________________________

________________________________________________

________________________________________________

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I AGREE THAT I WILL BE RESPONSIBLE FOR ANY FEES CHARGED BY THE SENDING PRACTICE.*

PATIENT SIGNATURE:____________________________________________________________

PATIENT NAME:_________________________________________________________________

PATIENT SOCIAL SECURITY #:______________________________________________________

PATIENT DATE OF BIRTH:_________________________________________________________

TRANSMITTAL DATE:_______________________________________
OFFICE INITIALS:__________________________________________

- **SENDING PRACTICE: PLEASE NOTE THAT ANY FEES SHOULD BE BILLED TO THE PATIENT DIRECTLY. NOT TO WOMAN CARE OF RALEIGH.**