Dr. Bradford Wolk
Hibiscus Women's Care, LLC
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PATIENT REGISTRATION FORM

Please complete both pages of this form using your legal name as it appears on your social security card.

Patient Name: _____ SSN: _____

Date: _____ Date of Birth: _____ Phone#: (___)_____ Cell#: (___)_____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed

Street Address: _____ City: _____ State: ____ Zip: _____

Employer: _____ Phone#: (____) _____

Street Address: _____ City: _____ State: ____ Zip: _____

Email Address: _____

Spouse or Guardian Name: _____ SSN: _____

Employer: _____ Phone #: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone#: (___)_____

Referred By: _____

Pharmacy Name: _____ Pharmacy Phone #: (____)_____

Primary Care Physician: _____ Phone #: (____)_____

INSURANCE: Please allow us to make a copy of your insurance card(s) and provide us with all pertinent information regarding your insurance coverage.

Primary Insurance Company: _____

Group#: _____ ID#: _____

Insured's Name: _____ Relationship to patient: _____

Secondary Insurance Company: _____

Group#: _____ ID#: _____

Insured's Name: _____ Relationship to patient: _____

LABORATORY TEST

Please be advised that during your examination there may be specimens (Pap Smear, HPV Testing, cultures, biopsies, etc…) obtained. This office does not perform laboratory testing on these specimens. Each specimen will be sent to an outside reference laboratory to be interpreted by a licensed pathologist/cytologist. This office does not charge for the collection of these specimens: however, you will receive a statement from the laboratory for services rendered. This office is not associated in any way with the reference laboratory, therefore, any questions regarding your statement will need to be directed to the laboratory performing the services at the telephone number on your statement.

I have read the above statement and do thereby consent to testing.

Patient Signature: _____

Witness: _____

MISSED APPOINTMENT POLICY

Please note that after the three missed appointment without notification, you may be dismissed from the practice.

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION AND AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

As a patient of this practice, I consent to the providers use and disclosure of Protected Health Information about me in order to carry out treatment, payment and health care operations. I have been informed about the provider's Notice of Privacy Practices, and that such notice provides a more complete description of the uses and disclosures that the provider may make concerning my PHI. I understand that I have the right to review such notice before signing this consent. I also understand that the terms of the notice may change and that I may obtain a revised copy of the notice by contacting the office. I fully understand my right to receive such notice and I consent to the provider's use or disclosure of PHI

I wish to be contacted in the following manner, check all that apply:

____ Home Phone ____Work Phone ____ Cell Phone _____ Mail ____Email

____ Okay to leave a detailed message _____ Leave a Message with call back number only

____ Okay to leave message with: _____

____ Do not leave messages with: _____

Signature: _____

NEW PATIENT OR PATIENT NOT SEEN

Name:_____ Date:_____

Reason for visit (Circle one): Medicare screening breast & pelvic exam*

Well Woman exam *

Problem: _____*

Consult ordered by another Physician

*PLEASE NOTE: Extra charges may apply if BOTH a well woman exam and problem visit is performed on the same day without proper authorization from your insurance company.

Primary Care Physician: _____ Last Seen: _____

Preferred Pharmacy Name & Location_____ Day supply: 30 90

Medications (Prescribed, Herbs and over the counter medications):_____

_____

_____

_____

Medication Allergies and reaction: _____

_____

Surgeries: _____

_____

_____

Age at onset of menstrual cycles: _____ Last menstrual period (date) or year of menopause: _____

Current Birth Control Method:_____ Are you planning pregnancy? _____

Are you sexually active at the present time? _____Has your partner had a vasectomy?_____

Have you ever used an IUD? _____ If yes, what type? _____

Number of Pregnancies: _____ Living children: ____ How delivered? _____

Number of miscarriages less then 12wks: _____ miscarriages between 12wks–24wks: _____

Number of elective abortions: _____ Ectopic pregnancies: _____ Stillbirths: _____

Please indicate if any of these "High Risk" factors apply to: Yes_____ No_____

- History of abnormal pap smears
- Mother took DES
- Sexually active before age 16
- More than 5 sexual partners
- Many full term pregnancies
- Personal history of cancer
- Human papillomavirus (HPV)
- Overweight or obese
- Diet low in fruits and vegetables

PERSONAL MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

High thyroid	Low Thyroid	Diabetes
Glaucoma	High blood pressure	Heart disease, heart attack
Asthma	High cholesterol	High triglycerides
Genital herpes	History of Chlamydia	History of genital warts
History of chickenpox	History of stroke or TIA	History of migraines
History of blood clots or DVT	Lupus	

Cancer: _____

Other: _____

Religious orientation: __Agnostic __Atheist __Christian __Jewish __Muslim Other:_____

FAMILY HISTORY (PLEASE CIRCLE ALL THAT APPLY)

Write which Family member next to circled history.

Breast Cancer_____	Uterine Cancer_____	Ovarian Cancer _____
Colon Cancer_____	Melanoma_____	Diabetes_____
High Cholesterol_____	Heart Attack or Heart Disease_____	Stroke_____
Blood Clots or DVT_____	Thyroid Disease_____	Osteoporosis_____

Other: _____

HEALTH RISK ASSESSMENT (PLEASE CHECK ALL THAT APPLY)

_____Tobacco Use: Packs per day?_____ How long? _____ Quit Date:_____

_____Alcohol Use: Occasionally:_____ Drinks per week:_____ Type: _____

_____Recreational drug use: Type: _____ How often: _____

_____Have you ever been or currently sexually or physically abused?

_____Not safe at home

PREVENTATIVE CARE (PLEASE CHECK ALL THAT APPLY)

_____Get regular exercise	_____Get regular dental care
_____Regular seatbelt use	_____Perform regular self breast exams
_____Regular sunscreen use/self skin exams	_____Take a Multivitamin

_____Adequate calcium intake (4-5 dairy servings per day or 1200-1500mg per day supplement)

_____Folic Acid supplementation (at least 400ug per day)

TEST/SCREENINGS/VACCINES (PLEASE NOTE APPROXIMATE DATE)

Mammogram_____	Pap smear_____
Bone Density _____	Colonoscopy_____
Cholesterol_____	Tetanus_____
Thyroid_____	Flu Vaccine_____

REVIEW OF SYSTEMS (Current Problems) If you circle yes, please explain.

Constitutional: Fatigue, fever, weight gain, weight loss.

Skin: Abnormal moles, rashes, acne, hair loss, excessive hair growth.

Eyes: Irritation, vision changes.

ENMT: Hearing loss, ear pain, nose problems, sinus problems, nosebleeds.

Respiratory: Difficulty breathing, shortness of breath, cough, wheezing,

sore throat, blood-tinged sputum

Heart: Chest pain, irregular heart beat, Shortness of breath with exertion.

GI: Heartburn, painful swallowing, nausea, vomiting, abdominal pain,

change in bowel habits, diarrhea, constipation, rectal bleeding.

GU: Blood in urine, abnormal bleeding, flank pain, trouble urinating, leaking urine, rash,

vaginal lesions, vaginal discharge, vaginal odor, vaginal itching, painful urination.

Endocrine:

Menstrual: Breast pain, bloating, anxiety, depression mood, PMS, menstrual Problems: painful periods, heavy periods, irregular periods, bleeding btw periods, nipple discharge, breast lump.

Menopausal: Hot flashes, night sweats, vaginal dryness, memory problems, concentration problems.

Sexual: No sex drive, painful intercourse, orgasmic problems.

Musculoskeletal: Muscle aches, muscle weakness, joint pain, back pain.

Neurologic: Headaches, dizziness, weakness, numbness, seizures, loss of consciousness.

Psychological: Depression, anxiety, alcoholism, drug addiction, sleep issues.

Signature:_____

Reviewed by: _____