Women Specialists of Katy
REGISTRATION FORM

PATIENT INFORMATION

Patient's name:			Marital status (circle one): Single / Married / Divorced / Separated / Widowed	
Social Security number:	Drivers License number:	Drivers License state:	Birth date: / /	Age:
Email address:				
Home phone : ( )	Cell phone : ( )		May we leave results on your voice mail? ❑ Yes ❑ No	
Street address:				
City:	State:	Zip Code:		
Employer:	Work phone : ( )	Occupation:		
Street address:				
City:	State:	Zip Code:		
How did you hear about us?	❑ Friend	❑ Doctor	❑ Other	

INSURANCE INFORMATION

Policy holder's name:	Birth date: / /	Phone : ( )	Employer:
Policy holder's Social Security number:		Policy holder's Drivers License number:	
Insurance company:		Insurance type (circle one): HMO / PPO / POS / EPO	
Group number:		Policy number:	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone: ( )	Work phone: ( )

Please be aware that we will accept and file a claim with your insurance, provided that you have a current insurance card and a contracted plan. All other claims must be filed by you. You are responsible for keeping our office informed of any changes in coverage. Your signature on this document authorizes Women Specialists of Katy to submit claims for services rendered without obtaining your signature on each claim filed.

I authorize my insurance company to pay and hereby assign Women Specialists of Katy all benefits, payable for services rendered. I understand that I am financially responsible for all charges.

Authorization signature *Date*

ALLERGIES

Drug	Reaction

MEDICATIONS

Drug	Dose	How often do you take this?

MEDICAL HISTORY

Please list all pregnancies, including miscarriages and terminations.

Date of delivery	Sex	Weeks Pregnant	Baby's weight	Hours in labor	C-section or vaginal	Hospital	Complications
/ /							
/ /							
/ /							
/ /							
/ /							
/ /							

Gynecological History

Last pap smear: / /	Any abnormal pap smears? ❑ Yes ❑ No	Details:
Last Mammogram: / /	Any abnormal mammograms? ❑ Yes ❑ No	Details:

Any problems with your period? ❑ Yes ❑ No	Details:

Sexually active: ❑ Yes ❑ No	Current birth control:	Last period: / /

PERSONAL MEDICAL HISTORY

Please check any that apply to YOU.

❑ Asthma	❑ Diabetes	❑ Heart murmur
❑ Lung disease / Pneumonia	❑ Lupus	❑ Other (please list)
❑ Cancer	❑ Thyroid disease	
❑ Ulcer / Bowel disease	❑ Migraine headache	
❑ Liver disease	❑ Tension headache	
❑ Heart attack / Stroke	❑ Glaucoma	
❑ Blood Clot	❑ Kidney stone	
❑ Hypertension	❑ Kidney infection (Pyelonephritis)	

Details:

SURGICAL HISTORY		
Surgery	Date	Reason for surgery
	/ /	
	/ /	
	/ /	
	/ /	

FAMILY MEDICAL HISTORY	
Disease	Family member(s) affected (Paternal grandmother, maternal aunt, brother, etc.)
❑ Cancer (type)	
❑ Diabetes	
❑ Hypertension	
❑ Thyroid disease	
❑ Heart disease	
❑ Blood clot	
❑ Other	

SOCIAL HISTORY	
Do you smoke? ❑ Yes ❑ No	Number of cigarettes per day:
Do you drink alcohol? ❑ Yes ❑ No	Number of drinks per day or week:
Do you use recreational drugs? ❑ Yes ❑ No	Please list:

MENTAL HEALTH HISTORY
Please describe any current or past mental health problems.

COMMUNICABLE DISEASES			
Disease	Date diagnosed		
❑ Gonorrhea	/ /	❑ Herpes	/ /
❑ Chlamydia	/ /	❑ Hepatitis B / C	/ /
❑ Syphilis	/ /	❑ HIV	/ /
❑ Other			/ /

REASON FOR VISIT