HerHealth
Washington Regional

Consent for Treatment

I authorize and consent to the rendering of medical care, including diagnostic procedures and medical treatment by authorized members of HerHealth as many in their professional judgment be necessary for the below named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment.

Assignment of Insurance Benefits

Patient-Physician Agreement: I, the undersigned, authorize HerHealth to release any information acquired in the course of my examination or treatment to my insurance company(s) or another physician. I, recognizing that the medical insurance I possess may not completely cover the fee(s) for professional services rendered me; hereby agree that I am responsible for said fee(s). I authorize payment directly to me for their services. A photocopy hereof shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

Authorization to Release Information

I authorize HerHealth to release any information requested by the insurance company necessary to collect benefits under any policy we make claim against for services on this or a related date of service.

Guarantee of Payment

I understand that office visits are to be paid for at the time of service unless other arrangements have been made. I understand that I am responsible for the balance not covered by insurance. I understand that HerHealth does not accept any insurance policy assignment as a guarantee of full payment.

Patient Signature:
X_____

_____
(Patient or Parent/Guardian if under 18 years of age)

_____
Relationship of Guardian

_____
Date

PATIENT INFORMATION- PLEASE PRINT

HerHealth Washington Regional

SOC SEC #: _____-_____-_____ **MRN#:**_____

Name: _____
Last First Mid Initial

Home Phone: _____

Work Phone: _____**Ext:**_____

Address: _____ **Cell Phone:** _____

City: _____ **Date of Birth:** _____-____-_____ **Age:** _____**yrs**

State: _____ **Zip Code:** _____ **Employer:** _____

SEX: ☐ **Male** ☐ **Female** **Work Address:** _____

City: _____ **State:** ____ **Zip:** _____

MARITAL STATUS: ☐ **Married** ☐ **Single** ☐ **Divorced**
☐ **Partner** ☐ **Widowed** **Separated** **Occupation:** _____

Email:_____**@**_____

PRIMARY CARE PHYSICIAN: _____

REFERRAL

Who referred you to our clinic? (***PLEASE CHECK BOX***)

☐ Washington Regional Medical Center
☐ Newspaper or Magazine
☐ Recommended by friend or family member
☐ Drove by Location of Clinic
☐ Community or Company Health Fair
☐ Treated by Physician in hospital
☐ Internet
☐ Phone Directory (Yellow pages)
☐ Referred by a Physician: _____
☐ Employer
☐ Insurance Plan Directory
☐Return Patient/ Not Applicable
☐ Other: _____

SPOUSE/PARENT INFORMATION

Spouse/Parent Name: _____ **Cell:** _____

Employer: _____ **Work:** _____ **Ext:** _____

Work Address: _____ **Spouse/Parent SEX:** ☐ **Male** ☐ **Female**

City: _____**State:** _____ **Zip:** _____ **Spouse/Parent Date of Birth:** _____/_____/_____

Occupation: _____ **Social Sec. #:** _____-_____-_____

EMERGENCY CONTACT INFORMATION

Emergency contact: _____ **Cell Phone:** _____

Address: _____ **Home Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Relationship to Patient:** _____

PRIMARY INSURANCE

Patient's Relationship to *Main Policy Holder*: ☐ **Myself** ☐ **Spouse** ☐ **Child** ☐ **OTHER:** _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ **State:** _____ **Zip:** _____

ID# _____ **Group #** _____

Insurance Company's Phone Number: _____

Main Holder's Name: _____ **Main Holder's Date of Birth:** _____/_____/_____

Main Holder's Address: _____ **Main Holder's Soc Sec#:** _____-_____-_____

City: _____

State: _____ **Zip:** _____

SECONDARY INSURANCE

Patient's Relationship to *Main Policy Holder*: ☐ **Myself** ☐ **Spouse** ☐ **Child** ☐ **OTHER:** _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ **State:** _____ **Zip:** _____

ID# _____ **Group #** _____

Insurance Company's Phone Number: _____

Main Holder's Name: _____ **Main Holder's Date of Birth:** _____/_____/_____

Main Holder's Address: _____ **Main Holder's Soc Sec#:** _____-_____-_____

City: _____

State: _____ **Zip:** _____

GENERAL INFORMATION

Who is responsible for Payment?: ☐ **Myself** ☐ **Other:**_____ **(FILL OUT BELOW)**

Responsible Party Name: _____ **Responsible Party DOB:** _____/_____/_____

Relationship to Patient: ☐**Self** ☐**Spouse** ☐**Child** ☐**OTHER** **SS#**_____-_____-_____

Address: _____ **Phone#:**_____

Have you ever been seen as patient at one of our Washington Regional Medical System Clinics? ☐ **Yes** **No**

If Yes, When?:_____/_____/_____ **Where?:**_____

RELEASE OF INFORMATION **(spouse, children, parents, etc)**

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

Preferred Language: ☐**English** ☐**Spanish** ☐**Marshallese** ☐**Arabic** ☐**DECLINE** **OTHER:** _____

Race: ☐ **White** ☐**African American** ☐ **Asian** ☐ **Native Hawaiian/Other Pacific Islander**

☐ **Native American Indian/ Alaskan** ☐**Hispanic** ☐**Unknown** ☐ **DECLINE**

Ethnicity (Origin): ☐ **Not Hispanic or Latino** ☐ **Hispanic or Latino** ☐**Unknown** ☐**DECLINE**

Preferred Communication Method: ☐**Print** ☐**Save to Flash Drive** ☐**DECLINE**

Wellness Reminders: ☐**Mail** ☐**Cell Phone** ☐**Home phone** ☐**Work Phone** ☐**DECLINE**

PREFERRED PHARMACY:_____ LOCATION:_____

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X_____ **Date:** _____/_____/_____

Signature (Patient or Parent/Guardian if minor)

HerHealth
Washington Regional

MRN#:_____
DATE: _____

PATIENT NAME _____ Age_____ DATE OF BIRTH _____

Reason for your appointment today (circle one)? Annual exam/Wellness Specific problem
If a specific problem, please describe: _____

SOCIAL HISTORY: MARRIED DIVORCED SINGLE WIDOWED STUDENT
What type of work do you do? _____

PLEASE CIRCLE ANY CONDITIONS YOU HAVE HAD. LIST ANY HEALTH CONDITIONS NOT COVERED:

Allergies	Glaucoma	Mitral valve prolapse
Anxiety	Headaches	Osteoporosis
Arthritis	Heartburn	Thyroid disease
Asthma	Heart murmur	Irritable bowel syndrome
Bipolar disorder	Hearing loss	Received Blood Transfusion
Blood clots	Hepatitis	Lupus
Blood in urine/stool	High blood pressure	Diabetes
CPAP	High cholesterol	COPD/emphysema
HIV	Depression	Cancer (type _____)
Defibrillator	Irregular Heart Beat	Other Conditions:_____

LIST ANY SURGERIES WITH DATES:

Type of Surgery	Date of Surgery

CURRENT MEDICATIONS (Prescriptions, Non-Prescriptions, Herbal or other Supplements)

Medication Name	Strength	How often do you take it?

St. John/s Wort	Yes	No	Aspirin	Yes	No
Gensing	Yes	No	Anti-coagulants	Yes	No
Ginko Bilboa	Yes	No	Diet Pills	Yes	No

ALLERGIES TO MEDICATIONS/ If no Allergies please write "none"

Name of Medication	Reaction

ALLERGIES TO: LATEX DYE ADHESIVE IV CONTRAST BETADINE

GYN HISTORY

At what age did you start menstruating? _____

When was your last menstrual period?
_____

Are your periods regular? _____

Have you had a hysterectomy? _____

If so, when? _____

Any abnormal pap smears? Yes No

If yes, what type of treatment did you receive? _____

_____

_____

Date of last Pap smear: _____

History of STD? _____

History of pelvic inflammatory disease? _____

Gyn History

- ☐ Heavy bleeding during period
- ☐ Bleeding between periods
- ☐ Severe cramps with period
- ☐ Painful intercourse
- ☐ Recent vaginal itching/discharge
- ☐ Monthly breast exams
- ☐ Lump in breast(s)
- ☐ Pain in breast(s)
- ☐ Complications with birth control pills
- ☐ On birth control pills now
- ☐ Have/are taking Hormone Replacements/Bioidenticals

Are you sexually active? _____

If so, what type of birth control are you using? _____

_____

Do you plan to have more children?
YES NO UNSURE

List ALL Pregnancies (with related information below):

Dates of Pregnancies	Type of Delivery	Any Complications	Baby's Birth Weight

FAMILY HISTORY—Please fill out the below Family History:

	Child	Mother	Father	Brother	Sister	Aunt (M/P)	Uncle (M/P)	Grandparent (M/P)
Breast Cancer								
Ovarian Cancer								
Uterine Cancer								
Colon Cancer								
Cervical Cancer								

	Mother	Father	Sister	Brother
Diabetes				
High Blood Pressure				
Heart Disease				
High Cholesterol				
Blood Clots				
Osteoporosis (post menopausal fractures)				

Social

- ☐ Drinks _____ caffeine drinks per day
- ☐ Smokes _____ packs per day ☐ Never Smoked
- ☐ Drinks _____ alcoholic drinks per day OR _____ socially
- ☐ Uses recreational drugs

Review of Symptoms

*Please **circle** ALL that apply*

Constitutional:

Fever
Chills
Feeling Poorly
Feeling Tired
Recent weight gain
Recent weight loss

Gastrointestinal:

Abdominal Pain
Constipation
Nausea
Diarrhea
Vomiting
Bloody Stools

Genitourinary:

Dysuria
Incontinence
Pelvic Pain
Dysmenorrhea
Vaginal Discharge
Abnormal Vaginal Discharge

Breast:

Breast Pain
Nipple Discharge
Breast Lump

Psychiatric:

Suicidal
Sleep Disturbances
Anxiety
Depression
Change in Personality
Emotional Problems

Lifestyle:

Do you consume a healthy diet? Y N

Do you exercise regularly? Y N

Any weight concerns? Y N

Have you ever had a mammogram? Y N
~If yes, last exam date_____

Have you ever had a colonoscopy? Y N
~If yes, last exam date_____

Have you had a bone density scan? Y N
~If yes, last exam date_____