NORTHWEST ASSOCIATES FOR WOMEN'S HEALTHCARE
1786 Moon Lake Blvd, Suite 207
Hoffman Estates, IL 60169
(847) 884-1800 Fax (847) 884-6768

Welcome to Northwest Associates for Women's Healthcare.

We want to thank you for allowing us the privilege to participate in your healthcare and we welcome you to our Practice.

We have enclosed two forms for you to complete in the comfort of your home. These forms are our Patient information/Registration form and our brief Medical History form.

The patient Information form is used to establish your chart and account with us. Accurate completion of this form will allow us to file your insurance claims to the appropriate insurance company in an accurate and timely manner. While some of the information may seem irrelevant or even redundant, it is information required by the various insurance carriers to process claims. In the event you have a secondary insurance plan, please inform us of this plan by including that information on this form as well. We will be happy to file claims to your secondary plan, as appropriate, following response to claim by your primary insurance plan.

The Medical History form serves as a tool to gather baseline information about you for your provider. Your past health history information and current concerns that you indicate on the form will facilitate your first visit with your provider.

Please **do not** mail the forms back to us. We ask that you bring them with you on the day of your appointment along with your insurance card and a photo ID.

Our office is located at the corner of Higgins Road and Moon Lake Boulevard, approximately two blocks east of Barrington Road. We are located in Suite 207.

We look forward to meeting you soon.

Sincerely,

The Physicians and Staff at Northwest Associates for Women's Healthcare

Fred Duboe, M.D., F.A.C.O.G.
Abby H. Freedman, M.D.

Gail Gerber, M.D., F.A.C.O.G
Debra Danielson, C.N.M.

NORTHWEST ASSOCIATES FOR WOMEN'S HEALTHCARE
PATIENT INFORMATION
(Please Print)

Welcome to our office

Marital Status
☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Separated

Name_____ **Date**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Phone (____) _____ **Work** (_____) _____ **Cell** (_____) _____

Email _____ **Birth date** _____ **SS #**_____/_____/_____

Race: ☐ White ☐ Hispanic ☐ Asian ☐ Black or African American ☐ American Indian or Alaska Native
☐ Native Hawaiian ☐ Other Race ☐ Refused or unreported

Language: ☐ English ☐ Other ☐ Indian ☐ Spanish ☐ Russian **Ethnicity:** ☐ Spanish ☐ Not Spanish ☐ Refused

Which Physician are you seeing?_____ **Primary/Family physician?** _____

Referred by: ☐ Dr. _____ ☐ Patient _____ ☐ Other _____ ☐ Telephone Book ☐ Internet

Employer _____ **Occupation** _____

Address _____ City _____ State _____ Zip _____

Name of husband or responsible parent _____ **Date of Birth** _____

Address _____ City _____ State _____ Zip _____

Employer _____ **Soc. Security #** _____

INSURANCE INFORMATION

Please give us all the pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, please Supply information for both carriers. Please list all numbers on your card(s). Please check your insurance policy for a waiting period before Coverage begins or pre-existing clauses. IF YOUR COVERAGE IS CONTIGENT ON A REFERRAL, SECOND OPINION OR PRE-ADMISSION APPROVAL, **IT IS YOUR RESPONSIBILITY TO INFORM US.**

ARE YOU COVERED UNDER INSURANCE THROUGH YOUR EMPLOYER/SCHOOL. ☐ **YES** ☐ **NO**

Ins.Co. _____ Group No. _____ I.D. No. _____

Address _____ City _____ State_____ Zip_____

Effective date of coverage _____

ARE YOU COVERED UNDER INSURANCE THROUGH YOUR HUSBAND'S OR PARENT'S WORK? ☐ **YES** ☐ **NO**

Ins. Co. _____ Group No. _____ I.D. No. _____

Address _____ City _____ State_____ Zip_____

Effective date of coverage _____

I authorize release of information to insurance carriers and/or other healthcare providers as may be necessary to file a claim Or facilitate my Health care. I ASSIGN PAYMENT OF BENEFITS TO THE HEALTHCARE PROVIDER/GROUP INDICATED ON THE .CLAIM I understand I am financially responsible for any balance not covered by my insurance carrier. Patient due balances Are due and payable within 30 days of statement. Accounts sent to an outside collection agency will be assessed a fee of 25% of the owed amount. A copy of this signature is as valid as the original.

Signature:_____ **Date**_____

– Please Give Receptionist Your Insurance Card to Copy –

Important: Complete Reverse Side

When we need to call you with lab results, to confirm your appointment, etc; may we:

Call you at home ☐ Yes ☐ No Call you on your cell phone ☐ Yes ☐ No

Call you at work ☐ Yes ☐ No

Leave a message on your answering machine ☐ Yes ☐ No

Leave a message on your voice mail ☐ Yes ☐ No

Leave a message with your family member ☐ Yes ☐ No

If yes, please identify him/her _____
(Name) (Relationship)

_____
(Name) (Relationship)

PATIENT AGREEMENTS AND AUTHORIZATIONS

Consent for Treatment. I hereby consent to the treatment provide by NWAWHC and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs.

Authorization for Release of Personal Health Information. I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operation of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

Assignment of Insurance Benefits/Payment Guarantee/Collection Fee. I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees.

Privacy Policy. I acknowledge having Northwest Associates for Women's Healthcare's Privacy Policy available to me, my rights, including the right to see and copy my record, to limit disclosure of my health information and to request an amendment to my record. I understand that I may revoke, in writing, my consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consent.

Routine communication of medical information. I acknowledge that the present communication method(s) that my physician and his/her staff follow to confirm appointments, inform me of my test results and changes to my treatment plan are acceptable to me. I acknowledge that I can request a reasonable alternative method of communication by listing it above.

Patient or Authorized Person Signature _____ Date_____

_____
Print Name

Witness Signature_____Unable to sign. Verbal consent given Reason:_____

ADDITIONAL INFORMATION

Emergency contact _____ Relationship _____

Address_____ City _____ State _____ Zip _____

Phone (_____) _____ Work phone (____) _____

Cell Phone(_____)_____

Pharmacy:_____

Address:_____

Phone Number:_____ Fax Number:_____

NORTHWEST ASSOCIATES *for* Women's Healthcare, S.C.

1786 Moon Lake Blvd. Ste 207 (main floor) Hoffman Estates, IL 847-884-1800

PERSONAL HISTORY

DATE:_____

NAME:_____ AGE:_____ DATE OF BIRTH:_____

MARITAL STATUS:_____ IF MARRIED, HUSBAND'S NAME:_____ RELIGION:_____

Are you here for a routine checkup?_____

Do you have any medical problems at this time?_____

GYNECOLOGICAL AND OBSTETRICAL HISTORY

Date of last menstrual period?_____ Was it normal?_____

What birth control are you now using? None PILL IUD Diaphragm Vasectomy Tubal Ligation Other_____

Age first period began_____ Number of days between_____ Days flow_____

Number of pads/tampons per day used at beginning of period_____ End_____

Are your periods Irregular?	Yes	No	Have you ever had a pelvic infection?	Yes	No
Pain with or prior to periods?	Yes	No	Have you passed the "Change of Life"?	Yes	No
Medication for pain with periods?	Yes	No	If "yes"		
Clots with periods?	Yes	No	Have you had any bleeding?	Yes	No
Any bleeding during or after sex?	Yes	No	Any hot flashes?	Yes	No
Any pain with sex?	Yes	No	Have you noticed any lumps or discharge		
Any abnormal vaginal discharge?	Yes	No	from breasts or nipples?	Yes	No
Have you ever had a venereal disease?	Yes	No	Do you lose urine when you		
Have you had German Measles?	Yes	No	cough or sneeze?	Yes	No

How many pregnancies?_____ How many living children?_____

How many miscarriages or abortions?_____ Any premature babies?_____

Age at first pregnancy?_____

PREGNANCIES: List in Order

Date	Sex	Weight	Complications (C-Section. etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

When was your last Pap smear? _____

ALLERGIES AND SENSITIVITIES: Allergic to:

a. Morphine, Codeine, Demerol	Yes	No	_____
b. Novocaine or other Anesthetics	Yes	No	_____
c. Aspirin or other Pain Medicine	Yes	No	_____
d. Tetanus or other Serum	Yes	No	_____
e. Adhesive Tape, Iodine, Foods	Yes	No	_____
f. Penicillin Tetracycline	Yes	No	_____
g. Sulfa Drugs, other Antibiotics	Yes	No	_____
h. Any other Drug or Medication	Yes	No	_____

DRUGS RECENTLY TAKEN: Within the past 6 months, have you taken any of the following? If so, when and what amount, if known.

a. Cortisone, ACTH ..... Yes No _____
b. Anticoagulants (Blood Thinners) ..... Yes No _____
c. Tranquilizers (Tension Relievers) ..... Yes No _____
d. Hypotensive (High Blood Pressure Medicine) . Yes No _____
e. Any other Drugs ..... Yes No _____

PAST HISTORY: Have you ever had any operations such as tonsillectomy, etc. List when, what type operation, where.

_____

_____

MEDICAL HISTORY: High Blood Pressure, Asthma, Hepatitis, etc._____

_____

Hospitalizations?_____

Serious Injuries?_____

Transfusions?_____When?_____

SKIN

Have prolonged bleeding from cuts? ..... Yes No
Ever had blood clots in legs? ..... Yes No

EYES

Wear glasses or contact lenses? ..... Yes No

EARS

Difficulty in hearing? ..... Yes No
Ringing in ears? ..... Yes No
Frequent dizzy spells? ..... Yes No

NOSE, MOUTH, THROAT

Frequent nose bleeds? ..... Yes No
Wear dentures? ..... Yes No
Sore, sensitive or bleeding gums? ..... Yes No
Frequent sore throats? ..... Yes No
Hay fever allergies? ..... Yes No

CHEST

Ever had high blood pressure? ..... Yes No
Heart trouble or murmur? ..... Yes No
Severe shortness of breath? ..... Yes No
Chronic cough? ..... Yes No
Ever cough up blood? ..... Yes No
Ankle Swelling? ..... Yes No
Heart often skip a beat or race? ..... Yes No
Heart pain? ..... Yes No

GASTROINTESTINAL

Chronic constipation or diarrhea? ..... Yes No
Recent change in bowel habits? ..... Yes No
Bloody or tarry stools? ..... Yes No
Gallbladder disease, ulcer? ..... Yes No
Jaundice, colitis? ..... Yes No

URINARY TRACT

Ever had kidney or bladder infection? ..... Yes No
Now have pain, urgency, or burning with urination ..... Yes No
Ever passed blood in urine? ..... Yes No
Ever had sugar in your urine? ..... Yes No

NEUROMUSCULAR

Ever had a convulsion? ..... Yes No
Ever had swollen, red or stiff joints? ..... Yes No
Have paralysis or deformity? ..... Yes No

ENDOCRINE

Any thyroid trouble? ..... Yes No
Ever been told you are diabetic? ..... Yes No
Has your weight varied over 10 lbs in last year? ..... Yes No

FAMILY HISTORY: Cancer, Diabetes, Heart Disease, Hypertension, Other:_____

SOCIAL HISTORY:

Martial Status:_____if married, How long?_____If divorced, how long?_____

If married, is your marriage satisfactory ? ..... Yes No
Are you usually depressed lately? ..... Yes No
Any special problems worrying you? ..... Yes No
Do you smoke? ..... Yes No
How much?_____

Do you drink? ..... Yes No
How much?_____
Are you presently taking any type of Medication now? ..... Yes No
If so what ?_____

_____
SIGNATURE OF THE PERSON COMPLETING THIS FORM

_____
RELATIONSHIP OF PATIENT (or "SELF")

_____
PATIENT NAME (Please Print)

_____
DATE