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 spouse 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 SPOUSE'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

1786 Moon Lake Boulevard, Suite 207 • Hoffman Estates, IL 60169 • 847-884-1800

PERSONAL HISTORY

DATE _____

NAME _____ AGE _____ DATE OF BIRTH _____

I prefer to be called: _____ Gender Identity: _____ Pronouns: _____

Marital Status _____ Partner/Spouse's Name: _____ Religion _____

Are you here for a routine checkup? _____

Do you have any medical problems at this time? _____

GYNECOLOGIC AND OBSTETRIC 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 your periods stopped due to menopause?	Yes	No
Do you use pain medication with periods?	Yes	No	If "yes"		
Clots with periods?	Yes	No	Have you had any postmenopausal 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

Total number of pregnancies _____ Number of pre-term deliveries _____

Number of miscarriages or abortions _____ Number of living children _____

Age at first pregnancy _____

PREGNANCY DETAILS

Date	Sex	Weight	Type of delivery and any complications

MOST RECENT TESTING:

	Date	Result	Where
Pap smear			
Mammogram			

SOCIAL HISTORY:

Do you feel safe in your intimate relationships?	Yes	No	Do you smoke or use E-cigarettes?	Yes	No
Have you felt depressed recently?	Yes	No	How many times per day? _____		
Any special problems worrying you?	Yes	No	Do you drink alcohol?	Yes	No
Do you feel safe at home?	Yes	No	How many drinks per week? _____		
Use of recreational drugs or non-prescribed pills?	Yes	No	Sexual orientation: _____		

ALLERGIES AND SENSITIVITIES:

CURRENT MEDICATIONS AND SUPPLEMENTS:

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

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

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/Chest 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 or colitis? ..... Yes No

URINARY TRACT

Ever had a kidney or bladder infection? ..... Yes No
Currently have pain, urgency or burning 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
Ever have paralysis or deformity? ..... Yes No

ENDOCRINE

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

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

Signature of the person completing this form

Relationship to patient (or Self)

Patient name (please print)

Date