Comprehensive Women's Care
11110 Medical Campus Road
Hagerstown, MD 21742
301-665-9098

PATIENT REGISTRATION - Please Print Clearly

Date: ______________

PATIENT NAME - LAST	FIRST	MIDDLE MAIDEN/PREVIOUS MARRIED NAME	DATE OF BIRTH
HOME ADDRESS	APT. NO	CITY	STATE / ZIP
HOME PHONE	CELLULAR/PAGER NUMBER	**SOCIAL SECURITY NUMBER**	PRIMARY CARE PHYSICIAN
MARITAL STATUS ☐ S ☐ M ☐ W ☐ D	EMAIL ADDRESS	**IS IT OK TO CONTACT YOU BY EMAIL?**	☐ **YES** ☐ **NO**
EMPLOYER		**WORK PHONE**	EXTENSION/DEPARTMENT
YOUR OCCUPATION	EMPLOYER'S ADDRESS		
SPOUSES NAME		SPOUSES BIRTHDAY	SPOUSES SOCIAL SECURITY
SPOUSES EMPLOYER	SPOUSES EMPLOYER'S ADDRESS		SPOUSES WORK PHONE

FOR MINORS ONLY (Under age 18)

MOTHER'S NAME	MOTHER'S ADDRESS	MOTHER'S HOME PHONE
MOTHER'S EMPLOYER	EMPLOYERS ADDRESS	MOTHER'S WORK PHONE
FATHER'S NAME	FATHER'S ADDRESS	FATHER'S HOME PHONE
FATHER'S EMPLOYER	EMPLOYER'S ADDRESS	FATHER'S WORK PHONE

HOW DID YOU HEAR ABOUT OUR PRACTICE? ______________________________

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?__________________ **PHONE:** ______________

What is the best day-time phone number to contact you for calling results? ______________

What is the best time to contact you at this number?______________________________

May we leave a message on your answering machine or voice mail? ______________________

Please complete the section below: I hereby authorize Comprehensive Women's Care to release any information required in the course of my examination or treatment to the following designated person(s).

Name of Designee(s) ____________________ **Phone Number**__________________ **Date** ______________

BILLING and INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	ID OR POLICY NUMBER	GROUP #/CODE	EFFECTIVE DATE
POLICY HOLDER NAME	POLICY HOLDER DATE OF BIRTH	POLICY HOLDER SOCIAL SECURITY	RELATION TO PATIENT
SECONDARY INSURANCE NAME	ID OR POLICY NUMBER	GROUP #/CODE	EFFECTIVE DATE
POLICY HOLDER NAME	POLICY HOLDER DATE OF BIRTH	POLICY HOLDER SOCIAL SECURITY	RELATION TO PATIENT

SEE REVERSE SIDE/NEXT PAGE

Please Read Carefully:

- All copays/coinsurances are due at the time professional services are rendered.
- I am personally liable for the fee(s) for services rendered unless such fees are covered under a specified contractual agreement.
- I authorize the release of any medical information to my insurance carrier concerning my treatment and I authorize payment directly to Comprehensive Women's Care for services rendered.
- For minor: I understand that I am fully responsible for this minor's medical charges and agree to pay all charges for services rendered by Comprehensive Women's Care.

Signature: ____ Date: ______________

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Office Use Only:

REGISTRATION INFO UPDATED:

DATE INITIALS

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Comprehensive Women's Care

David Solberg, M.D., Andrew Oh, M.D., Mitesh Kothari, M.D.
Katherine Walton-Vecchio, PA-C, Rebecca A. Kreps, PA-C
11110 Medical Campus Road, Suite 249
Hagerstown, Maryland 21742

PATIENT MEDICAL QUESTIONNAIRE

NAME: ____________________________ **DOB:** ________________________ **TODAY'S DATE:** _____________

DATE OF LAST EXAMINATION: ____________________ **LAST MENSTRUAL PERIOD:** ___________________

PLEASE READ THE FOLLOWING QUESTIONS AND MARK "YES" OR "NO". USE THE COLUMN ON THE RIGHT TO EXPLAIN ANY CONDITION MARKED "YES" OR USE THE BACK OF THIS PAGE. PLEASE USE INK PEN.

		YES	NO	EXPLAIN
1)	Do you have any drug allergies?	___	___	
2)	Are you currently taking medication on a regular basis?	___	___	
3)	Are your periods irregular?	___	___	
4)	Is your menstrual flow excessively heavy?	___	___	
5)	Do you have severe cramping?	___	___	
6)	What was the date of your last Pap smear?	___	___	
7)	Have you ever had an abnormal Pap smear which required treatment?	___	___	
8)	Have you ever had a sexually transmitted disease? (genital warts, herpes, chlamydia, etc.)	___	___	
9)	Do you lose urine or stool when you don't intend to? (coughing or sneezing)	___	___	
10)	Have you ever had a mammogram? (if so, please note date of last mammogram and where it was done)	___	___	
11)	Have you ever been pregnant? (If so, please list your pregnancies by year delivered, type of delivery you had, baby's sex, and birthweight, and any complications of pregnancy or delivery. Also please list any miscarriages or terminations.)	___	___	
12)	Have you ever been physically or mentally abused?	___	___	
13)	Are you currently under the care of a physician for a medical condition or problem? (please note condition)	___	___	
14)	Have you ever had surgery? (please note procedure)	___	___	
15)	Have you ever been admitted to the hospital for a nonsurgical reason?	___	___	
16)	Do you smoke/use tobacco? (if so, please list number of cigarettes per day)	___	___	
17)	Do you drink alcohol?	___	___	
18)	Do you exercise regularly?	___	___	
19)	Have any family members had:			
	*** cancer, leukemia, lymphoma?	___	___	
	*** high blood pressure, heart attack, stroke?	___	___	
	*** high cholesterol, diabetes?	___	___	
	*** kidney disease, kidney stones?	___	___	
	infertility, twins, birth defects?	___	___	

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