CLIENT REGISTRATION

Patient Information

			Preferred Pharmacy:
Last Name	First Name	Middle Initial	Nickname
Date of Birth	Female ☐ Male ☐	Social Security	Marital Status

PLEASE INDICATE YOUR RACE	PLEASE INDICATE YOUR ETHNICITY
☐ Alaskan Native/American Indian ☐ Asian ☐ Black/African American ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Multi-Racial	☐ Hispanic / Latino ☐ NOT Hispanic / Latino
Primary Language:	☐ Requires Translator

Address			
City	State	Zip	NOTE: Please understand that if we need to get in touch with you about abnormal test results and we are unable to reach you by phone and you do not return our phone calls, we are required to send letters to your mailing address. Your signature below indicates your understanding.

Home Phone	Work Phone	Cell Phone	Primary
Preferred Communications		Email	

How may we contact you? We may call, leave messages, email, or text you.

Mail	Home Phone	Work Phone	Cell Phone	Primary Phone	E-Mail
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Do you have medical insurance? ☐ Yes ☐ No	Name of insurance	Policy/Member #
Emergency Contact		Relationship
Home Phone	Work Phone	Cell Phone

Consent to Treatment

I hereby consent to medical treatment by the signing of this document. I am aware that payment is expected at the time of service, however, some services are available regardless of ability to pay. I understand that services are provided on a voluntary basis, and that I do not have to accept any method of family planning. I hereby authorize Womankind to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claims.

Client Signature	Date

Health Information Privacy Policy Acknowledgement

I, the undersigned acknowledge that I received a copy of Womankind's Notice of Privacy Practices which outlines policies, practices and procedures employed by Womankind to assure confidentiality of my medical records.

Client Signature	Date

No Show/Late Show/Late Cancellation Policy

Womankind will charge a $10.00 fee to patients who do not come to their appointments, who come too late to be seen for their appointments, or who cancel their appointments less than 24 hours in advance.

Client Signature	Date

Womankind

Health History

Date: _____ Patient Name: _____Age: ____ Reason for visit: _____

Check all that apply	You	Family	Practitioner's Notes
Stroke, High blood pressure			
Heart disease, Rheumatic fever			
Diabetes			
Cancer			
Breast cancer			
Blood disorders			
Lung disease, TB, Asthma			
Migraines, Seizures			
Mental or Emotional disorder			
Kidney, Bladder problems			
Liver, Gallbladder problems			
Skin problems or diseases			
Stomach or bowel problems			
Bone or muscle disease			
Thyroid or metabolic disorders			
Blood clots, varicose veins			
PID - Pelvic inflammatory disease			
STI – Sexually transmitted infections			
HIV or AIDS			
DES Daughters			
Fertility problems			
Abnormal pap smears		NA	
Surgery or hospitalization		NA	
Blood transfusion		NA	
Other			

I have my period every: _____ My menses last for: _____I have stopped having periods: _____
Number of pregnancies: _____ Number of miscarriages or abortions: _____ Living children: _____
Birth control method: _____ Pregnancy desired: _____
Hormone replacement therapy: Currently: _____ Previously: _____Never: _____Do you have irregular menses? Yes No

***ALLERGIES*:**
Drug: _____ Food: _____ Others: _____
Daily medications, supplements, herbals: _____
_____
Are all immunizations up to date? _____ Rubella status: _____
When I have sex it is with: MEN – WOMEN – BOTH • I use condoms: ALWAYS – SOMETIMES – NEVER •
My previous/current sexual partners have been:
Injection drug user – bisexual – HIV/AIDS positive – with someone who has had more than 5 different sexual partners.

***CIRCLE YES OR NO*:**
Have you ever had sex to get drugs/money or place to live? Yes No • Used injected drugs? Yes No •
Have you ever been forced to have sex against your will? Yes No • Been a victim of sexual assault or abuse? Yes No
Has a partner ever hurt, kicked, pushed, slapped, bit or shoved you? Yes No •
Do you have pain or bleeding with sex? Yes No • Is your sex life satisfactory? Yes No – How long with current partner? _____
Do you smoke? Yes No – How many per day? _____ • Drink Alcohol? Yes No • Drug use? Yes No •
Recent weight change? Yes No – Exercise type and frequency: _____
***GIVE DATES OF LAST*:**
PAP: _____ Name of place where it was performed:_____
Menstrual period: _____ Mammogram: _____ Hemoccult: _____ Colonoscopy: _____ Cholesterol Test: _____

Practitioner's Signature: _____