

CHRISTIANA CENTER FOR WOMEN'S WELLNESS
David M Fink, M.D.

PATIENT REGISTRATION

Name
Street address
City
State
Zip Code
Home telephone () **Work ()** **Cell ()**
Date of Birth
Social Security Number
Marital Status: (please circle one): S M W SEP D

Emergency Contact Name and phone number

E-Mail address
How did you hear about our practice?

INSURANCE INFORMATION

Primary Insurance Company Name
Id #
Group #
Claims mailing address
Phone number

Insured's name (if other than patient)
Insured's address

Insured's telephone number ()
Insured's social security number (required) - -
Insured's date of birth (required) / /

Secondary Insurance Company Name (If applicable)
Id#
Group #
Claims mailing address
Phone number

Insured's name
Insured's address

Insured's telephone number ()
Insured's social security number (required) - -
Insured's date of birth (required) / /

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PATIENT HISTORY

Patient name
Date of birth
Social security number

MENSTRUAL HISTORY

When was your last menstrual period?
How old were you when you started your cycles?
How long do you bleed a month?
Are your periods regular? Yes or no. Explain: -

Do you have painful periods or PMS? Yes or no Explain: _____
Menopausal? Yes or no
Peri-menopausal? Yes or no
Post-menopausal? Yes or no

Current birth control method:
Previous birth control method:

Have you had an Abnormal Pap Smears? Yes or no. If so when? _____ And what treatment has been done if any? _____.

When was your last mammogram? _____ Normal? Yes or no
Have you had a DEXA/Bone scan? Yes or no Normal? Yes or no

PATIENT/FAMILY HISTORY

P/F

{ } Hypertension
{ } Headaches
{ } HEENT
{ } Respiratory problems
{ } Breast disease
{ } Jaundice / Hepatitis
{ } Gallbladder disease
{ } Bowel disorder
{ } Kidney problems
{ } Urinary tract problems
{ } Anemia / Blood disorders
{ } Blood transfusions

Comments:

P/F

{ } Varicose veins/Phlebitis
{ } Diabetes
{ } Thyroid disease
{ } Cancer
{ } Uterine Cancer
{ } Ovarian Cancer
{ } Cervical Cancer
{ } Epilepsy/Neural disorders
{ } Smoking: Cig / Day
{ } How long?
{ } Interested in stopping?
{ } Alcohol: Oz / wk

OBSTETRICAL HISTORY

Have you had any premature births? Yes or no Explain: _____

Have you had any miscarriages? Yes or no Explain: _____

Have you had any abortions? Yes or no. If yes how many? _____

BIRTHS

Month/year Duration of Gestation Duration of labor Type of delivery Complications Sex

- 1.
- 2.
- 3.
- 4.
- 5.

Please list any current medications that you are currently taking:

Please list any drug allergies that you are aware of:

INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature _____

Date _____

I hereby authorize Dr. David M Fink, M.D., to apply for benefit on my behalf for covered services rendered by his order. I request that payment from my insurance company be made directly to Dr. David M Fink.

I certify that the information I have reported with regard to my insurance coverage is correct.

Signature _____