Wellesley Women's Care, P.C.

PPG____

Thank you for taking the time to complete this form. We ask that you complete this entire form once a year **or** when you have any *NEW* information.

PATIENT INFORMATION (Please print clearly)

Name _____ DOB____/____/____ SS#____/____/_____

Street Address_____City/State/Zip_____

Home (_____)_____-_____Cell(_____)_____-_____Work(_____)_____-_____

Emergency Contact_____ _____Day Phone(_____)_____-_____

Email (optional)_____
You are welcome to include your email address, although it is not intended to be a primary contact method for your physician and/or our office.
Primary Care Physician _____Phone(_____)_____-_____

Are we able to leave a voice mail message at the numbers you have provided?	YES	NO
Do you want a chaperone present during your exams?	YES	NO

PRIMARY INSURANCE INFORMATION
Insurance Company / Address_____

Policy / Certificate #_____Group#_____

Policy Holder Name_____ _____Relationship to patient Self / Spouse / Parent / Partner

Policy Holder Employer_____

Policy Holder SS# _____/_____/_____ DOB____/_____/_____

Policy Holders address (if different from patient)_____

Secondary Insurance Information
Insurance Company / Address_____

Policy / Certificate #_____Group#_____

Policy Holder Name_____ _____Relationship to patient Self / Spouse / Parent / Partner

Policy Holder Employer_____

Policy Holder SS# _____/_____/_____ DOB____/_____/_____

Policy Holders address (if different from patient)_____

Insurance Authorization and Assignment (ALL PATIENTS)

I hereby authorize Wellesley Women's Care, P.C. to furnish information necessary to the above insurance carriers concerning my illnesses and treatments. I hereby assign WWC,P.C. all payments for medical services rendered with out a valid referral that may be required by my HMO, all services provided to me, if at the time of service my insurance carrier does not contract with WWC,P.C. and any amount not covered by my insurance.

Patient / Guardian Signature_____Date_____

MEDICARE PATIENTS ONLY MEDICARE AUTHORIZATION AND PAYMENT REQUEST
I certify that the above information given by me in applying for under Title XVII of the Social Security Act is correct. I authorize Wellesley Women's Care, P.C. to release any medical information about me to the Social Security Administration or intermediaries or carriers needed for medical claims. I request that payment of authorized benefits be made on my behalf to WWC, P.C. I assign benefits payable to WWC, P.C. for the services rendered, to WWC, P.C.

Patient / Guardian Signature_____Date_____

Wellesley Women's Care Annual Gynecological Update

Name: _____DOB: ____/____/_____

Todays Date:_____

Present Marital Status: S M D W Sep

		Yes	No
1.	Have you had any tests since your last visit? If yes, please specify. Mammogram, x-rays, lab work etc.		
2.	Have you been hospitalized or had any surgery since your last visit? If yes, please specify.		
3.	Have there been any illnesses or deaths in your family, since your last visit? If yes, please specify illnesses and/or causes of death and individuals relationship to you.		
4.	Have you developed new allergies since your last visit? If yes, please specify.		
5.	Have you started taking any new medications since your last visit? If yes, please specify. Prescription and non- prescription including calcium, HRT, vitamins or herbal supplements		
6.	Have there been any changes to your diet since your last visit ? If yes, please specify.		
7.	Do you exercise regularly? If yes, please specify activity and hours per week.		

8. Below please indicate any changes in your medical status since your last visit:

Menstrual cycle changes	Menopausal Symptoms	Marital or Sexual Problems	Sexually Transmitted Disease
Vaginal infections/ discharge	Bladder/Urinary problems	Changes in appetite	Weight loss or gain
Bowel problems / pain	Abdominal pain	Breast Discharge	Other, please specify

9. **Indicate your weekly consumption of the following since your last visit:**

Alcohol : Wine _____Beer_____Cocktails_____ **Caffeine** : Coffee_____Tea_____Soda_____

Cigarettes- Packs per day:_____

10. Preventative Health		Yes	No
Is domestic violence a concern for you?			
Do you use seatbelts?			
Do you do self breast exams ?			
Are you up to date with your vaccinations?			
11.	Has there been any change in the frequency of your sexual activity since your last visit? If yes, please specify		
12.	Are you currently using birth control ? or have you used emergency contraception ? If yes,please specify.		
13.	If you are currently NOT using birth control and are sexually active, please indicate for how long ?		
14.	Are you currently trying to conceive a baby? If yes, for how long?		
	IF YOU'RE NO LONGER HAVING PERIODS, YOU HAVE COMPLETED THIS FORM, THANK YOU		
15.	First date of your last period?		
16.	Usual length of time between periods:		
17.	Usual number of days your period lasts:		
18.	Do you suffer from cramps? If yes, are they Mild Moderate Severe		
19.	Do you spot or bleed between periods?		