Women's Cancer and Wellness Institute

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Name _____ DOB: _____/_____/_____

Address _____

City _____ State _____ Zip _____

Social Security Number _____ (for hospital records only)

Home Phone: _____ Cell Phone: _____
May leave message with health information on voice mail? Home: Yes/No Cell: Yes/No

Email: _____ Best Form of Contact: _____

Emergency Contact Name _____

Relationship: _____ Number: _____

Employer Name & Phone _____

Insurance Information

(Please Complete All Information Below)

Primary Insurance _____

ID Number _____ Group _____

Policyholder's Name _____

Policyholder's Date of Birth ____/____/____ Social Security Number ____-_____-_____

Secondary Insurance _____

ID Number _____ Group _____

Policyholder's Name/DOB _____

I hereby authorize the release of information to insurance carriers and/or other medical professionals, and for benefits to be paid directly to WCWI. Should this account become delinquent, I agree to pay all collection and court costs, including attorney's fees.

Signature _____ Date _____

Patient Authorization for Use or Disclosure of Health Care Information

I hereby authorize **Women's Cancer & Wellness Institute** to use the following protected health information and/or disclose the following protected health information to:

Please list name (s) of individual (s) who are privileged to your personal health information:

_____

_____

_____

_____

Note: If an individual's name is not listed, we cannot speak to them about your health care.

This authorization form applies to all records and information.

This protected health information is being used or disclosed at the request of the patient and/or power of attorney.

This authorization shall be in force and effect until treatment is completed or at which time this authorization expires.

Appointment Cancellation, No Show, FMLA and/or Short-term Disability Paperwork Policies and Fees

Appointments require 24 hours' notice to cancel/reschedule, or you may incur a fee of up to $75, pending the appointment type.

There will be a $25.00 fee for all patient paperwork (FMLA, Short-term disability or paperwork required by your employer) required to be filled out by our staff. Please allow 7-10 business days for all paperwork to be filled out and returned to you. Fees are due when the paperwork is submitted for completion.

I understand that I have the right to revoke this authorization, in writing, at any time, by sending such a request to **WCWI** at 1401 Johnston Willis Drive, Suite 1100, North Chesterfield, VA 23235 or 9101 Stony Point Drive, Suite 3300, Richmond, VA 23235. I understand that a revocation is not effective to the extent that **WCWI** has relied on the use or disclosure of the protected health information.

Name _____ Date_____

Signature _____ Date_____

Patient Name: _____ DOB: ____/____/____

Age _____ SSN _____ (Used to Access Hospital Records Only)

Primary Care Physician _____

Ph: _____ Fax: _____

Who referred you today _____

Ph: _____ Fax: _____

Reason for Visit_____

Other Physicians that you see_____

Pharmacy Name & Number _____

Medications (include prescription and over the counter)

Medication	Dosage	Reason

Allergies _____

Past Medical History (Circle if you have/had)

Heart problems / Stroke / Blood Clot / Asthma / Cancer: _____

High Blood Pressure / Diabetes / Arthritis / COPD / Osteoporosis/Other_____

Gynecologic History

Pregnancies _____ Miscarriages _____ Abortions _____ # of living children_____

Year of last Mammogram_____ Age at First Baby_____ Age at First Period_____

Date of Last Pap_____ History of Breast Feeding_____ Colonoscopy/Year _____

History of Birth Control_____ History of Hormone Replacement Therapy_____

List of Surgeries/Hospitalizations with dates & physicians (if known)

_____

_____

_____

Social History

Occupation (if retired, previous occupation) _____

Marital Status: (circle) Single Married Widowed Divorced Separated

Cigarette Use: Nonsmoker / Smoker / Packs per day _____/ # of year's ____/ Prior smoker

Alcohol Use # of drinks: weekly / monthly _____ Recreational Drug Use: Yes / No

Patient Name: _____ DOB: ____/____/____

Review of Symptoms (Please circle all that apply):

General	Fever	Poor Appetite	Weight Loss	Weight Gain	Fatigue	None	
Eyes	Glasses	Contacts	Blurry Vision	Double vision	Pain	None	
Ear/Nose/ Throat	Sore Throat	Mouth Sores	Sinus Problems	Nose Bleeds	Ear Infection	None	
Respiratory	Cough	Wheezing	Asthma	Trouble Breathing	Shortness of breath	none	
Cardiovascular	Palpitations	Chest Pain	High Blood Pressure	Heart Attack	Bypass/ Stents	Stroke	None
Blood/Lymph	Swollen Glands	Bleeds Easily	Abnormal Blood Clotting	Blood Clot	None		
Breasts	Lumps	Pain	Nipple Discharge	Cancer	None		
Gastrointestinal	Nausea	Heartburn/ Pain	Blood in Stool	Abdominal Swelling	Constipation	Diarrhea	None
Urinary	Leak Urine	Painful Urination	Frequent Urination	Blood in Urine	None		
Reproductive	Vaginal Bleeding	Vaginal Discharge	Irregular Periods	Pain	Bleeding after sex	Fibroids	None
Musculoskeletal	Leg Swelling	Joint Pain	Neck Pain	Back Pain	Swollen joints	None	
Skin	Rash	Itching	Lumps	None			
Endocrine	Unusual thirst	Heat Intolerant	Cold Intolerant	Hot Flashes	Irregular periods	none	
Neuro/Psych	Tremors	Dizziness	Numbness	Sadness	Anxiety	None	

Family History (Please Check):

	Mother	Father	Sibling	Children	Aunts/Uncles/Grandparents
Breast Cancer					
Uterine Cancer					
Ovarian Cancer					
Colorectal Cancer					
Pancreatic Cancer					
Prostate Cancer					
High Blood Pressure					
Diabetes					
Stroke					
Heart Problems					
Blood Clots					
Other					

Additional Information: _____

_____

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