

New Patient Demographics

Last Name: _____ First Name: _____ Middle: _____

Nickname/Preferred Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please circle the number where we may leave a detailed, confidential message.

Email Address: _____

Preferred Pharmacy Name: _____

Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____

How were you referred to our office?

Patient (name): _____

Facility (full name): _____

Physician (first and last name): _____

Social media (which platform): _____

Employer Information

Name: _____

City: _____ State: _____ Zip Code: _____

Position: _____ Status: Full-Time Part-Time

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Your insurance is necessary for us to process any insurance claims and to ensure payments of service rendered.

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Chicago Women's Health Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature (Patient and/or guardian if minor): _____ Date: _____

New Patient History

Name: _____ Date: _____

Please help us provide you the best healthcare by completing this short questionnaire.

What brings you to the office today? _____

What are your gender pronouns?

- She, her, hers, herself
- He, him, his, himself
- They, them, theirs, themselves
- Ze, hir, hers, himself
- Just my name, please
- Other _____

What is your ethnicity/ancestry?

- Ashkenazi Jewish
- Asian
- Black/African American
- French Canadian
- Hispanic/Latinx
- Mediterranean
- Native American or Alaska Native
- Pacific Islander or Native Hawaiian
- Sephardic Jewish
- White/Caucasian
- Other _____

What medications are you currently taking? (Please list each medication and your current dose.)

1. _____

3. _____

2. _____

4. _____

Do you have any of the following health problems?

- Asthma Yes No
- High blood pressure Yes No
- High cholesterol Yes No
- Heart disease Yes No
- Diabetes Yes No
- Thyroid issues Yes No

- Migraines/Headaches Yes No
- Anxiety Yes No
- Depression Yes No
- Postpartum depression Yes No
- Other: _____

Do you have allergies to any medications? Yes No

If yes, please list _____

Have you ever had surgery? (If yes, please list.)

1. _____

3. _____

2. _____

4. _____

Do you have a family history of any of the following? (If yes, please list which family member)

Breast cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____	High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____
Ovarian cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____	Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____
Uterine cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____
Colon cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____
Pancreatic cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____	Thyroid disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____
Melanoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____	Bleeding disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____	Blood clotting disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____

Social History

Do you drink Alcohol? Yes No

If yes, how many drinks per week? _____

Have you ever felt the need to cut down on drinking? Yes No

Do you smoke Cigarettes or Vape? Yes No

If yes, how many per day? _____

Do you use marijuana? Yes No

Do you use any other recreational drugs? Yes No

If yes, please specify _____

What is your occupation? _____

Do you exercise? Please specify how often and what type: _____

Are you currently:

Single In a Relationship Engaged Married Divorced Widowed

Obstetric & Gynecologic History

Date of your last menstrual period _____

Do you have any concerns about your periods? _____

Do you use a method of contraception? Yes No

If yes, please indicate which type: _____

Do you have sex with men, women, or both? _____

Do you have a history of any sexually transmitted infections? Yes No

If yes, please indicate which ones: _____

Date of your last Pap Smear _____

Do you have a history of abnormal pap smears? Yes No

Did you receive the HPV / Gardasil vaccine? Yes No

Date of your last mammogram _____

Have you had an abnormal mammogram? Yes No

Have you had a breast biopsy or surgery? Yes No

Have you ever been pregnant? Yes No

PATIENT FINANCIAL POLICY

Thank you for choosing Chicago Women's Health Group as your healthcare provider. Our primary mission is to provide our patients with outstanding medical care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Carefully review the following information and return this form with your signature and today's date. Please ask if you have any questions about our fees, our policies, and/or your responsibilities.

You will be asked to fill out a new patient information form at your first visit. Please notify our office at your follow-up visit(s) if any of the information has changed.

All self-pay services must be paid prior to your visit. Please see the billing department when you arrive for your appointment.

As a courtesy to you, we file your claims to your insurance company. Amounts not covered by your insurance are your responsibility. All copayments must be paid at the time of your visit. If you are not prepared to pay your copay, your appointment may be rescheduled. Payment of your balance after insurance is expected within 30 days unless payment arrangements have been made with our billing department. We accept cash, checks, Visa, MasterCard, Discover, and American Express. There is a \$25 fee for checks returned due to insufficient funds. If you do not understand your statement or have questions regarding your balance, please feel free to contact our billing department at 312-943-0282 option 3 for clarification.

ADDITIONAL NOTES

Appointments must be canceled or rescheduled at least 24 hours prior to your appointment time or you will be subject to a \$50 fee. We have reserved an appointment time for you and most likely will not be able to fill it at the last minute.

If you have any questions regarding billing, please contact our billing department at 312-943-0282 option 3 from 8:00 a.m. to 4:00 p.m. Additionally, you are always welcome to stop by our office when you are here for an appointment. We are happy to assist you!

Sign: _____

Date: _____