Eastside Women's Health & Lactation **Registration Form**

Name:	Today's Date:	
Birth Date:	Baby's Birth Date:	
Street Address:	City, State, Zip:	
Cell Phone:	Home:	Work:
Occupation:	Employer:	
Email:	Subscribe to e-newsletter? Yes No	
How did you hear about EWHL?		
INSURANCE INFORMATION Please give your insurance card and photo ID to the receptionist.		
Primary Insurance:		
Insurance ID #:	Group #:	
Co-Pay: $		
Subscriber's Name	Subscriber's Birth Date:	
Subscriber's SS #:	Relationship to Subscriber:	
Secondary Insurance:	Subscriber Name:	
Group #:	Policy #:	
Baby's Insurance (if different from Mom):	Subscriber Name & SSN:	
Group #:	Policy #:	
IN CASE OF EMERGENCY		
Name: Relationship:		
Cell Phone: Work Phone:		
AUTHROIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION		
May we call you at home? Yes No	May we leave a message at your home? Yes No	
May we leave a message on your cell? Yes No	May we call you at work? Yes No	
I acknowledge& agree to adhere to the Notice of Privacy Practices as required by federal & state guidelines. I understand I may request/review a copy of these Practices at any time from the office staff. I permit the release of any information, including my medical records that may be requested by my insurance company to process any claims.		
Patient/Guardian Signature:	Date:	
CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INORMATION		
I have completed this form and certify that I am the patient or legal guardian of patient. I authorize the providers of Eastside Women's Health & Lactation (EWHL) to provide medical care and treatment for me. I authorize payments of benefits to be made directly to EWHL. I understand that as the recipient of services, regardless of insurance coverage, that I am ultimately responsible for payment within 30 days of the date of service or statement and billing fees may be assessed. Failure to pay in 30 days could result in a $10 late fee.		
Patient/Guardian Signature:	Date:	

Eastside Women's Health & Lactation **New Patient/Initial Intake Form-GYN**

Name:	Today's Date:	
Birth Date:	Age:	Social Security #:
Allergies:	Your Primary Care Provider:	
Marital Status:	Your occupation:	
Reason for today's Visit:		

Menstrual History

Age when period first started: First day of last period:

# of days you bleed: # of days between periods:

Any problems with period? Y N Amount of bleeding: Heavy Medium Light

Sexual History

I have sex with (circle one): Men Women Both Bi-Sexual partners Not active

Age at first intercourse: Date of last pap smear?

I have had or my partner has had a new partner in the last year: Yes No Not active

Do you have any bleeding or pain with sexual activity? Yes No

How do you protect yourself from sexual transmitted infections?

Pregnancy History

# of full term pregnancies: # of premature pregnancies: # of vaginal births:

# of c-sections: # of miscarriages: # of abortions: # of ectopic preg.:

# of living children: Ages of children: # of children placed for adoption:

# of children adopted:

Contraceptive History

Current method of birth control: Problems with it? Yes No

Other methods used in past: Want to changing methods? Yes No

Menopause and Beyond

Age you stopped having periods: Problems or concerns? Yes No
Taking hormone therapy (HT)? Yes No

Gynecological/Medical/Surgical History- check if you have or have had

☐ Abnormal uterine bleeding	☐Pelvic Pain	☐Abnormal pap smear/treatment
☐Fibroids	☐Endometriosis	☐Warts
☐Ovarian cysts or tumors	☐Premenstrual syndrome	☐Pelvic Infection
☐Loss of urine or feces	☐ Vaginitis (yeast, BV, trich)	☐Chamydia/Gonorrhea
☐Infertility issues	☐Herpes	☐Breast Pain/Discharge

Health & Nutrition

I exercise _____ times a week. What type of exercise do you do?_____
I take calcium. Yes No How much? _____ I take vitamin D. Yes No How much? _____
Amount of drink in a week: alcohol _____ tea _____ coffee _____
Do you smoke? Yes No If yes, how much? _____
Do you use street drugs? Yes No If yes, what kind and how often?

Describe your diet.

Medical and Family History ☐I have no knowledge of my family history.

Check if YES:	Self (S)	Family (F)	Check if YES:	S	F	Check if YES:	S	F
Breast cancer			High cholesterol			Skin problems		
Insomnia			Muscle/joint pain			Vision problems		
Ovarian cancer			High blood pressure			Jaundice/hepatitis		
Colon cancer			Blood clots lungs/legs			Asthma		
Uterine cancer			Thyroid problems			HIV/AIDS		
Other cancer			Lung problems			Anemia		
Diabetes			Breast problems			Birth defects		
Heart disease			Colon/Stool problems			Varicose Veins		
Rheumatic fever			Reflux/ulcer			Migraines		
Stroke			Stomach problem			Headaches not migraines		
Osteoporosis/Fracture			Gall bladder problem			Seizure/epilepsy		
Shortness of Breath/Chest Pain			Kidney/bladder proble			Depression		
Arthritis/joint pain			Urine infections			Anxiety		

List any hospitalizations, surgeries, accidents or serious illness and their year.

Please list any medications, herbs, vitamins, and supplements you are taking:

Prevention

Would you like information about vaccinations? Yes No

Because it is so common and we are concerned about your safety, we ask all patients about the presence of violence in their home and relationships. We want you to be safe, and we can help. Are you being:

☐Hurt
☐Insulted or talked down to
☐Screamed at or cursed
☐Threatened with physical harm
☐I have a history of sexual/physical abuse.

To the best of my knowledge, the questions on this form have been answered correctly.

_____
Patient Signature

I have read and reviewed the information provided by the patient/guardian above.

Kristina Chamberlain, CNM, ARNP, IBCLC

Financial Contract & Office Policies

As a patient of the Eastside Women's Health & Lactation, and by signing below, I agree to the financial responsibilities for any fees not covered by my insurance carrier and to the office policies listed below. Any outstanding fees must be paid at time of service. I also understand that it is my responsibility to confirm insurance coverage before my scheduled appointment.

Fees, Third Party Billing & Co-pay Policy: In addition to the policy stated above, inability to pay your co-pay at the time of service will incur a $10 service charge. If you have any questions regarding your insurance coverage or fees, you can contact your insurance directly, or contact Alternative Medical Billing Service, LLC at (206) 932-0870. If you are self pay, you may contact the office for a fee schedule.

Insufficient Funds Policy: If a check does not clear due to insufficient funds, a $25 fee will be added to the outstanding balance.

Late Policy: EWHL respects your time, and we ask that you respect ours. Appointments are not double-booked and do not intentionally run over. If you are more than 10 minutes late for your appointment, you may be seen for any time remaining or asked to reschedule. If you expect to be late, please let Kristina Chamberlain know as soon as possible by calling the office at 425-814-2045.

No Shows/Cancellations Policy: If you need to cancel an appointment, please do so within 24-48 business hours of the appointment time. Business hours do not include weekend or holidays. Appointments cancelled with less than 24 hours notice will incur a $30 fee for a follow- up appointment and $50 for an initial appointment. Three unexplained no-shows will result in dismissal from the practice.

Phone & Email Consults: Brief questions can be answered over the phone or email at no charge. Complex concerns will not be answered this way; it is not good practice and can result in less optimal care. If you have a more complex concern, you will be asked to make an appointment, or you will be charged $50 for a more involved phone/email consult.

_____ _____

Name of Patient (Print) *Signature of Patient*

_____

Today's Date

EWHL's Consent for Treatment and Acknowledgement of Receipt of Notice of Health Information Privacy Practices and Consent to Disclosures

Name of Patient: _____ Today's Date: _____

Date of Birth: _____ Phone: _____

As a patient of the Eastside Women's Health & Lactation and by signing below:

I hereby authorize Kristina Chamberlain, CNM, ARNP, IBCLC to provide care, perform general diagnostic procedures and exams as necessary to facilitate my diagnosis and treatment.

I understand that I may ask questions regarding my diagnosis, treatment, fees, and insurance coverage, or any other aspect of my care before signing this form. With this knowledge, I voluntarily consent to the policies and procedures of Eastside Women's Health & Lactation.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during visits. I understand that free interpretive services may not be available and that I may be referred to another health care facility to provide the services necessary for my care.

No guarantee has been or will be given to me as to the results that may be obtained from any services I receive. I know that it is my choice to obtain these services and that I may change my mind about receiving medical care from Eastside Women's Health Services at any time.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive test results to the public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if a referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by a representative or me, or otherwise permitted or required by law.

I understand that I have the right to review my record and obtain a copy of my record upon request (see *Notice of Privacy Practices*) and that obtaining a copy of my record may require payment of a fee.

I hereby certify that I have reviewed the *Notice of Privacy Practices* for Kristina Chamberlain, CNM, ARNP, IBCLC/Eastside Women's Health & Lactation that is available on the website**.** I understand that if I have objections or concerns with this policy, I must notify Kristina Chamberlain, CNM, ARNP, IBCLC.

_____ *Today's Date* _____

Patient Name (printed)

_____

Signature by Patient/Parent/Guardian