# PATIENT REGISTRATION

Patient _____ Home Phone (_____)_____-_____

Address _____ Work Phone (_____)_____-_____

City _____ State _____ Zip _____ Cell Phone (_____)_____

Birthdate _____ Social Security # _____-_____-_____ DL# _____

E-Mail Address _____

How did you hear about us? Billboard, Phone Book, Intranet, Fly the Flag, Face Book,

Individual _____ Other _____

Patient's Employer _____

Employer's Address _____ City_____ State _____ Zip_____

How Long? _____ Phone (_____) _____ Dept. /Ext_____

_____

Spouse's Name _____ D.O.B. _____ Soc. Sec# _____-_____-_____

Spouse's Employer _____ Phone # (_____)_____ How Long? _____

Employer's Address _____ City _____ State_____ Zip _____

_____

PERSON TO CONTACT, OTHER THAN SPOUSE, IN CASE OF AN EMERGENCY

Name _____ Relationship _____

Address _____ Phone# (_____)_____

_____

What Provider will you be seeing? _____

What kind of insurance do you have? _____

_____

Race: American Indian or Alaskan / Asian / Black / Caucasian / Declined / Other / Pacific Islander

Ethnicity: Hispanic / Non-Hispanic / Declined Language: _____

Marital Status: Single Divorced Widowed Married Legally Separated

## Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

* * Yo he leído la Noticia de Practicas Privadas, que explica como mi información medica será usada y distribuida. Yo entiendo que tengo el derecho de recibir una copia de este documento.* *

_____ _____

Patient's Printed Name / * Nombre del Paciente * Patient's Social Security Number

_____ _____

Patient's Date of Birth / * Fecha de Nacimiento * Date / * Fecha *

_____

Description of Personal Representative / * Relación al Paciente *

_____

Additional person(s) authorized to receive any personal information/ *Personas adiciónales a quien podemos dar información personal*

I hereby assign to Athens Women's and Children's Center., and any assistant surgeon and/or anesthesiologist of his choice, all money to which I am entitled for medical/or surgical expense relative to the service rendered by him, but not to exceed my indebtedness to said physicians and/or surgeons.

I understand I am financially responsible to said doctors for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be required. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services.

* * Yo acuerdo dar a Athens Women's and Children's Center., y cualquier asistente cirujano y/o anestesiólogo de su escoger, todo dinero debido para crujías o asistencia médica relacionado al servicio dado por él, pero que no exceda mi deuda a dichos doctores y/o cirujanos.* *

* * Yo entiendo que soy financieramente responsable a dichos doctores por los cargos no cubiertos por este acuerdo. Yo consiento que en dicho caso de que no pague, asumo la responsabilidad de pagar el precio de colección, y/o precio de corte, y/ó precio razonable para asuntos legales si son necesarios. Yo autorizo que mi información médica sea dada a mi seguro medico y sus agentes para determinar la necesidad de estos beneficios ó el pago de estos beneficios ó servicios relacionados.

_____ _____

Signature of Patient or Personal Representative / Firma Date / Fecha

# Accessing your medical information online

**Your access information**

To access your medical information, navigate to the Web page listed below and then enter your assigned username and password.

**Name:**_____

**DOB:**_____

**Web page:**_____**https://webview.mckesson.com/awcc**_____

**Your username:**_____

**Your password:**_____

## Logging in

**To log in:**

1. Go to the Web page listed above.
2. In the **Username** field, type your username.
3. In the **Password** field, type your password.
4. Click the **Login** button. The patient chart page appears.

**To view your chart information once you log in:**

- On the left sidebar menu, click the item you want to view. The information appears in the center of the page.

## Logging out and exiting

You should always log out of your online chart when exiting, especially if you are accessing the product from a shared or public computer

**To log out:**

- Click the Logout link that appears at the top left side of the page. The login screen will appear, verifying that you logged out successfully.

I UNDERSTAND THAT MEDICAL PROVIDERS OF THE ATHENS WOMEN'S AND CHILDREN'S CENTER WHO WILL BE EXAMINING ME INCLUDE **PHYSICIANS, CERTIFIED NURSE MIDWIVES, ADVANCED NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.**

- Advanced Nurse Practitioners are professional nurses educated to provide the full range of primary care services in the community and hospital settings. They are certified by the American Nurses Association or by nursing specialty organizations. They hold licenses from the state as Registered Professional Nurse Practitioners.
- Physician Assistants are skilled members of the health care team who are educated to work dependently with physicians and under their supervision provide diagnostic and therapeutic patient care.
- Certified Nurse Midwives are individuals educated in the two disciplines of nursing and midwifery, who posses certification according to the requirements of the American College of Nurse Midwives. In addition in the state of Texas, they hold license as Registered Nurses and Advanced Nurse Practitioners.

I understand that I may request to be seen by a physician.

I authorize release of any information required for payment of provider and/or hospital charges for services rendered by the Athens Women's and Children's Center or by one of its clinics. I further authorize release of information to any hospital or medical facility I present myself to for medical care.

Yo he leído la información contenida al reverso de esta página en español y creo que la entiendo completamente. Todas mis preguntas en este tema/asunto han sido completamente contestadas.

Patient Name_____ Date of Birth_____

_____ _____

**Patient's** Signature/ Firma del Paciente Date/Fecha

_____ _____

Guardian's Signature/Firma del Tutor Date/Fecha

**NAME:** _____

*DATE OF BIRTH:* _____

*REASON FOR VISIT:* _____

*REFERRED BY:* _____

ATHENS Women's & CHILDREN'S CENTER

*Patient History Form*

## OBSTETRIC HISTORY

| | *Year* | *M/F* | *Weight* | *Length of Pregnancy* | *Type of Delivery* | *Problems* |
|---|---|---|---|---|---|---|
| # of Pregnancies ____ | | | | | | |
| # of Full-Term Deliveries ____ | | | | | | |
| # of Premature Deliveries ____ | | | | | | |
| # of Miscarriages/Ectopics ____ | | | | | | |
| # of Abortions ____ | | | | | | |

## GYNECOLOGIC HISTORY

Age of first period: _____

Last menstrual period: _____

Cycles: every ____ days Cycles are: ☐ Regular ☐ Irregular

lasting ____ days Flow is: ☐ Light ☐ Moderate ☐ Heavy ☐ Painful

Sexual preference: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Birth control method: _____

Any history of sexually transmitted diseases? ☐ Y ☐ N

Last Pap Smear: _____ Any history of abnormal tests? ☐ Y ☐ N

Last Mammogram: _____ Any history of abnormal tests? ☐ Y ☐ N

Last Bone Scan: _____ Any history of abnormal tests? ☐ Y ☐ N

Last Colonoscopy: _____ Any history of abnormal tests? ☐ Y ☐ N

## MEDICAL HISTORY

*Have you ever had any of the following?*

- ☐ High Blood Pressure
- ☐ Heart Disease/Attack
- ☐ Stroke
- ☐ Blood Clots
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Bleeding Problems
- ☐ Asthma
- ☐ Migraines
- ☐ Thyroid Disease
- ☐ Depression/Anxiety
- ☐ Cancer
- ☐ Other: _____

## SURGICAL HISTORY

*Please list all of your surgeries:*

_____ date _____ _____ date _____

_____ date _____ _____ date _____

## MEDICATIONS

*Please list all of your current medications & vitamins:*

_____ _____ _____ _____

_____ _____ _____ _____

## ALLERGIES

*Please list all of your allergies:*

☐ None _____

_____ _____

## SOCIAL HISTORY

Marital status: _____ Religion, if any: _____

Occupation: _____ Any abuse, emotional or physical? ☐ Y ☐ N

| | | | |
|---|---|---|---|
| Do you exercise? | ☐ Y ☐ N | Type & frequency: | _____ |
| Do you drink caffeine? | ☐ Y ☐ N | How much? | _____ |
| Do you smoke? | ☐ Y ☐ N | How much? | _____ |
| Do you drink alcohol? | ☐ Y ☐ N | How often? | _____ |
| Do you use drugs? | ☐ Y ☐ N | Which ones? | _____ |

## FAMILY HISTORY

*Has anyone in your family ever had any of the following?*

- ☐ High Blood Pressure
- ☐ Heart Disease/Attack
- ☐ Breast Cancer
- ☐ Uterine Cancer
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Colon Cancer
- ☐ Ovarian Cancer
- ☐ Blood Clots
- ☐ Down Syndrome
- ☐ Cystic Fibrosis
- ☐ Tay-Sachs Disease
- ☐ Bleeding Problems
- ☐ Neural Tube Defect
- ☐ Sickle Cell Disease
- ☐ A/B-Thalessemia