Divekar & Associates – Gynecology, Aesthetics & Wellness Center

Patient Registration Form Date:

Patient Information

Name:			Birthdate:		
SSN:	Age	Sex: ○ M ○ F	Marital Status: ○ M ○ S ○ W ○ D ○ Other		
Address:		City:	State:	Zip:	
Home Phone:	Work Phone:		Cell:		
Employer:			Occupation:		
Emergency Contact:			Relationship:	Phone: :	
Nearest Relative:			Relationship:	Phone: :	
Primary Care Physician:			Patient Email:		

Primary Insurance (Please present card for verification)

Insurance Name:		Copay (PCP):	Copay (Specialty):	
Address:		City:	State:	Zip:
Subscriber Name:		Sex: ○ M ○ F	Birthdate:	
Subscriber Address:			Phone:	
Insurance Id:	Group:		Effective Date:	
SSN:	Relation to patient:	Employer:		
Employer phone:		Occupation:		

Person Responsible for bill (If other than self or legal guardian if under age 18)

Name:			Birthdate:		
SSN:	Age:	Sex: ○ M ○ F	Marital Status: ○ M ○ S ○ W ○ D ○ Other		
Address:		City:	State:	Zip:	
Home Phone:	Work Phone:		Cell:		
Employer:		Occupation:			
Relationship to Patient:					

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Patient Name: **Date of Birth**

Reason of visit: ☐Annual ☐Problem

Last Period:	Menstrual history:	Sexually active - ☐Yes ☐No Partner ☐Male ☐Female Birth Control:

Pregnancy

Date	Week gestation	Weight	Labor length	Sex	Type of delivery	Complications (if any)

Past Medical History	Past Surgical History

Dates for -

PAP Smear HPV Vaccine COVID Vaccine	Mammogram Colonoscopy Bone Density

Family Health History:

Mother:	Maternal grandparent:
Father:	Paternal grandparent:
Brother:	Other: FH ☐Breast ☐Ovarian ☐Uterine ☐Colon cancer
Sister:	FH ☐DVT ☐PE

Smoking:	Alcohol:	Drug use:
Allergies:		

To be filled in office:

Height	Weight	BP

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Patient Name: **Date of Birth**

Medications:

Review of Systems: (Check all that apply)

CONSTITUTIONAL	CARDIOVASCULAR	GENITOURINARY	PSYCHIATRIC
☐Fever	☐Chest pain	☐Incontinence	☐Depression
☐Weight gain	☐Shortness of breath on exertion	☐Dysuria (Painful urination)	☐Nervous/Anxious
☐Weight loss	☐Palpitations	☐Urgency/Frequency	☐Insomnia (Trouble sleeping)
☐Malaise/Fatigue (Tired)	RESPIRATORY	☐Hematuria (Blood in urine)	☐Memory loss
Skin	☐Shortness of breath	☐Heavy Bleeding	NEUROLOGICAL
Eyes	☐Wheezing	☐Pain with periods	☐Headaches
ENT	☐Cough	☐Pain with sex	☐Dizziness
BREAST	GASTROTESTINAL	☐Bleeding after menopause	☐Lightheadedness
☐Breast Lump	☐Heartburn	☐Vaginal Discharge	☐Numbness/Tingling
☐Nipple Discharge	☐Dysphagia (painful swallowing)	☐Decreased Desire	ENDO/HEME
☐Painful breasts	☐Nausea	☐ Hot Flashes	
ALLERGY/IMMUNE	☐Abdominal pain	☐Vaginal Dryness	Additional Problems
☐Seasonal allergies	☐Diarrhea	MUSCULOSKELETAL	
☐Latex allergy	☐Constipation	☐Back pain	
☐Iodine allergy	☐Blood in stool	☐Joint pain	

I am having none of these symptoms at this time ☐

Date: Signature: