COYLE INSTITUTE
Female Pelvic Medicine & Reconstructive Surgery

Registration Form

Patient Name: _____

Date of Birth: _____

Last Name	First	Middle	
Street Address	City	State	Zip Code
Phone Number	Cell Phone	Date of Birth	Social Security Number
E-mail Address			
Gender: ◉ F ○ M	Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated ○ Other: _____		
	Ethnicity: ○ African-American ○ Asian ○ Caucasian ○ Hispanic ○ Other: _____		
Employer	Employer's Phone		
Street Address	City	State	Zip Code
Responsible party, if patient is a minor:			
Last Name	First	Relationship to Patient	Gender: ○ F ○ M
Street Address	City	State	Zip Code
Phone Number	Cell Phone	Date of Birth	Social Security Number
Primary Care Physician	Address		Phone
Referring Physician/Friend	Address		Phone
Insurance Information:			
First Insurance Company	Policyholder's Name		DOB
Social Security Number	Policy Number		Group Number
Policyholder's Employer			
Second Insurance Company	Policyholder's Name		DOB
Social Security Number	Policy Number		Group Number
Policyholder's Employer			

I have read and accept the HIPAA Agreement: ○ **YES** ○ **NO**	**I have read and accept the Notice of Privacy Practices:** ○ **YES** ○ **NO**

I consent to treatment for myself or my above listed minor child. I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or any third party payor within a reasonable amount of time, not to exceed 60 days. If this account is assigned to collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Signature	Date
Witness	Date

Include this form in the individual's records.

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Registration Form

Patient Name: _____

Date of Birth: _____

In Case of an Emergency, Please Contact:

Name	Relationship
Primary Phone Number	Secondary Phone Number

I, _____, do hereby give any physician, staff, employee, or representative of the **Coyle Institute** my permission to discuss my account and medical conditions, which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected information, excluding copies of my personal medical records, to the following person(s) in order to facilitate and coordinate my care, treatment, and payment:

Name of Individual Receiving Information	Relationship	Phone Number

I have been informed of the Privacy Act and I understand that the **Coyle Institute** will only be allowed information to the people listed above. I also understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to **Coyle Institute** or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s) it may be subject to re-disclosure by the individual(s).

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Include this form in the individual's records.

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Medical History

Patient Name: _____

Date of Birth: _____

Today's Visit

What is the reason for today's visit?

Hospitalization

Have you ever had surgery, including outpatient surgery? O Yes O No

Year	Reason	Year	Reason

Have you ever been admitted to a hospital? O Yes O No

Year	Reason	Year	Reason

Have you ever had a blood transfusion? O Yes O No

Year	Reason	Year	Reason

Medical History

Personal YES	Personal NO		Family YES	Family NO
O	O	Asthma	O	O
O	O	Arthritis	O	O
O	O	COPD	O	O
O	O	Diabetes	O	O
O	O	Heartburn	O	O
O	O	Heart Disease	O	O
O	O	High Cholesterol	O	O
O	O	High Blood Pressure	O	O
O	O	Mental Illness	O	O
O	O	Stroke	O	O
O	O	Seizures	O	O
O	O	Breast Cancer	O	O
O	O	Ovarian Cancer	O	O
O	O	Uterine Cancer	O	O
O	O	Colon Cancer	O	O
O	O	Other Cancer	O	O
O	O	Parkinson's	O	O
O	O	Alzheimer's	O	O
O	O	Alcoholism	O	O

Medication

Are you taking any medications, including over-the-counter or non-traditional?

O Yes O No

Are you allergic to any medications?

O Yes O No

Healthcare Exceptions

Do you have any non-drug allergies?

O Yes O No

Do you have any religious or moral limitations concerning your health?

O Yes O No

Include this form in the individual's records.

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Medical History

Patient Name: _____

Date of Birth: _____

Gynecologic History

Age when period started: _____ How many days does it last? _____
Period occurs every: ○ <21 days ○ 21-30 days ○ 30-35 days ○ >35 days

Do you have menstrual cramps/pain? ○ Yes ○ No
How severe? ○ Mild ○ Moderate ○ Severe

Do you ever bleed between periods? ○ Yes ○ No
Do you ever bleed after intercourse? ○ Yes ○ No

What do you use for contraception?

Have you gone through menopause? ○ Yes ○ No At what age? _____
Date of last Pap Smear? _____ Was it normal? ○ Yes ○ No
Have you ever had an abnormal Pap Smear? ○ Yes ○ No
If so, did you have: ○ Cryo ○ Colpo ○ Leep
Date of last mammogram? _____ Was it normal? ○ Yes ○ No
Do you perform breast self-exams regularly? ○ Yes ○ No
Date of last colonoscopy: _____

Have you ever had: Please Check Only Those That Apply

☐ Fibroids	☐ Ovarian Cysts	☐ Vaginal Dryness/Itching
☐ Endometriosis	☐ Hot Flashes	☐ Pelvic Inflammatory Disease
☐ Genital Herpes	☐ Genital Warts	☐ Yeast Infection
☐ Gonorrhea	☐ Syphilis	☐ Bacterial Infection

Urinary Problems

Do you have:

- ☐ Urine Loss with Cough
- ☐ Urine Loss with Urgency
- ☐ Urinary Urgency
- ☐ Urinary Frequency
- ☐ Pain with Urination
- ☐ Blood in Urine
- ☐ Bladder Infections
- ☐ Difficulty Urinating
- ☐ Bed Wetting
- ☐ Waking at Night to Urinate
- ☐ Wear Incontinence Products
- ☐ Uncontrollable Loss of Stool

Habits

	YES	NO
Alcohol	○	○
Caffeine	○	○
Cigarettes	○	○
Cigars	○	○
Coffee	○	○
Exercise	○	○
Illicit Drugs	○	○

Obstetric History

How many times have you been pregnant? _____ Live births? _____
Baby Weight: _____ Type of Delivery: _____
Baby Weight: _____ Type of Delivery: _____
Baby Weight: _____ Type of Delivery: _____
Baby Weight: _____ Type of Delivery: _____
Baby Weight: _____ Type of Delivery: _____

Sexual History

Are you sexually active? ○ Yes ○ No
Do you ever have pain with intercourse? ○ Yes ○ No
Is your sex life satisfactory? ○ Yes ○ No
Sexual preference: ○ Male ○ Female ○ Both

Symptoms

Have you recently had or experienced any of the following?

☐ Constipation	☐ Chest Pain	☐ Weakness/Numbness
☐ Diarrhea	☐ Heart Attack	☐ Suicidal Thoughts
☐ Soiling Pants with Stool	☐ Skin Problems	☐ Swollen Glands
☐ Blood in Stool	☐ Abnormal Hair Growth	☐ Breast Lumps
☐ Vomiting Blood	☐ Headaches	☐ Hoarseness
☐ Appetite Change	☐ Change in Vision	☐ Coughing Up Blood
☐ Sudden Weight Change	☐ Change in Hearing	☐ Difficulty Breathing
☐ Depression	☐ Difficulty Sleeping	

Include this form in the individual's records.

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Privacy Notice Acknowledgement

Patient Name: _____

Date of Birth: _____

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Medical Record Number: _____ Social Security Number: _____

Date of Admission: _____ Notice Version (Date): _____

Acknowledgement of receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Privacy Practices Notice from the **Coyle Institute** for Female Pelvic Medicine and Reconstructive Surgery.

Further, by signing below, I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment, and health care operations as discussed in the Privacy Practices Notice.

Patient Signature: _____ Date: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt)

Describe your good faith effort to obtain the individual's signature on this form:

Describe the reason why the individual would not sign this form:

SIGNATURE (Representative):

I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Title: _____

Include this form in the individual's records.