WOMEN'S CANCER AND SURGICAL CARE, P.C.

4610 Jefferson Lane NE Albuquerque, NM 87109
Tel: (505) 559-4495 Fax: (505) 842-8025
Email: info@wcscnm.com www.wcscnm.com

Initial Intake

Date: _____/_____/_____

Name: _____

DOB: _____/_____/_____ Social Security Number: _____-_____-_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: (_____)_____ Cell phone: (_____)_____

Email: _____

Employer: _____ Work phone: (_____)_____

Emergency Contact: _____

Phone Number: (_____)_____ Relationship: _____

Primary Care Physician: _____

Do you want WCSC to send Medical Records to your PCP? ☐ Yes ☐ No

Referring Provider: _____

Pharmacy Name: _____

Pharmacy Location: _____

Insurance Information

	Primary	***Secondary***
Insurance Name:	_____	_____
Claims Address:	_____	_____
	_____	_____
Policy ID Number:	_____	_____
Group Number:	_____	_____
Co-Pay Amount for Specialist:	_____	_____
Name of Policy Holder:	_____	_____
Relation to Policy Holder:	_____	_____
Policy Holder's DOB:	_____	_____
Policy Holder's SS#:	_____	_____

I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES: ☐ Yes ☐ No

Statement of Financial Responsibility:

I certify that the above information is true to the best of my knowledge. I hereby authorize my insurance benefits to be paid directly to Women's Cancer and Surgical Care, PC. I understand that I am financially responsible for any balance on my account and for any charges incurred by not providing the most current, correct insurance information to Women's Cancer and Surgical Care, PC. I also authorize Women's Cancer and Surgical Care, P.C. to release any information required to process my claims through my insurance carrier.

_____ _____/_____/_____

Patient / Responsible Party Signature Date

NOTE: If requesting FMLA and/or disability forms to be filled out, allow 10 business days for completion. A $ 25.00 fee will be charged and the payment is expected when requesting these forms.

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Patient Name: _____ DOB: _____/_____/_____

I hereby request and authorize Women's Cancer and Surgical Care, PC to:

☐ **RELEASE** Information ☐ **OBTAIN** Information

Name of Provider/Facility_____

Address: _____

Telephone: (_____)_____ Contact Person: _____

The purpose of this release is: (check all that apply)

☐ Moving ☐ Insurance Purposes ☐ Transferring Care

☐ Second Opinion ☐ Personal Review

☐ Other (please specify) _____

The following Protected Health Information (PHI) may be released: (please check one)

☐ I consent to the release of ***all medical records*** with the following exceptions, (Specifically describe the information you do not wish to have released)

_____

☐ I consent to the release ***all medical records*** relating to the following treatment and Condition:

_____

☐ I consent to the release of ***all medical records*** from _____to_____

This authorization will automatically expire within one year from the date of signature.
I understand that I have the right to revoke this authorization in writing at any time, except where information has already been released in response to this authorization.

NOTICE TO PATIENT: The first 10 pages are free of charge. After that there is a fee of $0.50 per page for copying and administrative costs.

Signature of Patient / Representative / Legal Guardian Date

Reason for Visit: _____

Have you had any of the following symptoms in the past 6 months: **(Mark with an X if it applies)**

Constitutional:

___ Weight increase or decrease
How many pounds? _____
___ Changes in appetite
___ Changes in sleep
___ Changes in energy level
___ Fever
___ Unable to do normal activities like getting dressed, preparing meals, taking a shower on your own, etc.

Pain

Where? _____
For how long? _____
Does it travel? _____
What increases or decreases it? _____
_____

Skin

___ Rashes
___ Sores
___ Skin tags or lesions
___ Changes in moles

Breast

___ Tenderness
___ Nipple discharge
___ Masses
___ Armpit lumps

HEENT

___ Changes in vision
___ Changes in taste
___ Changes in hearing
___ Changes in smell
___ Bleeding from the nose or gums
___ Sinus problems
___ Hair loss
___ Increased hair growth
Other (please specify)_____

Muscle Skeletal

___ Joint pain
Which joints? _____
___ Swelling
___ Muscle weakness
___ Difficulty walking
___ Hand(s) weakness

Neurologic

___ Abnormal sensations (numbness, tingling)
Where? _____
___ Dizziness
___ Unstable gait or change in balance
___ Seizures
___ Arm or leg weakness
___ Headache
___ Fainting / Change in speech

Cardiac

___ Chest pain
___ Palpitations
___ Previous arrhythmias
___ Previous heart attacks
___ Swelling of legs
___ Shortness of breath
Do you require a pillow to sleep at night _____
Can you go up a flight of stairs without shortness of breath _____
Can you walk a block without getting short of breath _____
Do you see a cardiologist _____
Who _____

Pulmonary

___ Dry cough
___ Cough with mucus or blood
___ Pain with breathing
___ Hay fever or other allergies
Do you see a pulmonary doctor _____
Who _____

Gastrointestinal

___ Nausea
___ Vomiting
___ Diarrhea
___ Constipation
___ Difficulty swallowing
___ Reflux
___ Blood in stool
___ Early fullness when eating

Urinary

___ Blood in urine
___ Leakage of urine
___ Urine infections
___ Kidney problems
___ Waking up to urinate
___ Pain on urination

What increases or decreases it? _____

_____

___ Irregular periods
___ Difficulty getting pregnant
___ Pain with intercourse

Hermatologic

___ Previous blood clots ___ Night sweats
___ Previous anemia or low blood counts
___ Easy bruising

Psychiatric

___ Anxiety ___ Depression ___ Difficulty Concentrating
___ Mood Swings

Past Medical History

___ Diabetes ___ Thyroid problems
___ High blood pressure ___ Asthma
___ Heart attacks ___ Previous blood transfusion
___ Previous cancer, if so, what type:_____
___ HIV
___ Hepatitis C
Other Chronic Infections: _____

Past Surgical History

___ Appendectomy
___ Gallbladder removal
___ Tubal Ligation
___ Hysterectomy
___ Removal of ovary(ies)
___ Breast surgery
___ Trouble with anesthesia or recovery from surgery
Other _____

Family History	**Mother**	**Father**
Any history of blood clots	____	____
Diabetes	____	____
High Blood Pressure	____	____
Stroke	____	____
Heart Disease	____	____
Mental Iilness	____	____
Cancer	____	____

Family History of Cancer

Maternal Side ____ **Paternal Side** ____

Number of pregnancies loss _____
Any ectopic pregnancies _____
Any molar pregnancies _____
Number of vaginal births _____
Any cesarean sections _____

Past Gyn History

Last menstrual period _____
Age at first menstrual period _____
Any bleeding in between periods _____
Do you use contraception _____
What types _____
_____
When was your last pap smear _____
Have you ever had an abnormal pap smear _____
Are you curently sexually active_____
_____
Have you ever had a sexually-transmitted disease
(e.g. gonnorrhea, chlamydia) _____
_____
At what age did you start Menopause_____
Have you taken hormone replacement therapy _____
_____
Age at first intercourse_____

Social History

Do you smoke _____
Do you drink alcohol _____
Are you Employed _____
Exercise_____
Maritial Status_____
Education_____
Who is your main emotional support _____
_____
Do you have a living will _____
Power of attorney _____
Occupation _____
When was the last time you had a:
Colonoscopy_____
Mammogram _____
Bone Density _____
Cholesterc _____
Glucose Cl _____
TSH

Patient Name: _____ DOB: _____

WOMEN'S CANCER AND SURGICAL CARE, P.C.

Medication List

Please list all medications with name, dosage, and frequency

Please list all of your prescription medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list all of your over-the-counter medications:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list all of your herbal medications:

1. _____
2. _____
3. _____
4. _____
5. _____

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Release of Medical Information to Family

I, _____
(Name)

Date of birth: _____ / _____ / _____

Authorize Women's Cancer and Surgical Care, P.C. to give medical information regarding the following specific condition(s):

- □ All Information
- □ Blood Work
- □ Pap smear
- □ Procedures and Results
- □ Medication Information/Refills
- □ Appointment Information

To: _____
(Name)

who is related to me as my: _____

□ ***I release Women's Cancer and Surgical Care, P.C. from any liability resulting from the release of this confidential information.***

□ ***I DO NOT authorize Women's Cancer and Surgical Care, P.C. to release ANY medical or appointment information to ANYONE.***

Signature: _____

Date: _____