


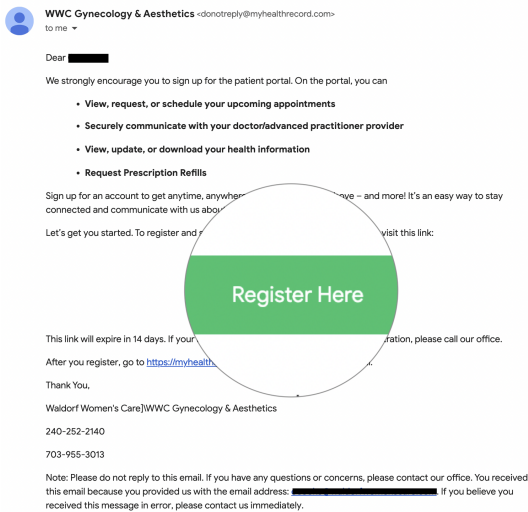
NEW PATIENT - PORTAL REGISTRATION & PAST MEDICAL HISTORY UPDATE

1. After you have been registered, you will receive a [email from WWC Gynecology & Aesthetics](#) to register for the patient portal.

   **WWC Gynecology & Ae.** Patient Portal Registration with Waldorf Women's Care/WWC Gynecology & Aesthetics

2. Open the email and click **REGISTER**

Patient Portal Registration with Waldorf Women's Care/WWC Gynecology



3. Confirm your identity with the [Name, DOB and Zip](#) you provided our medical receptionist.

Confirm Identity

Please confirm your identity to verify your account.
Use the exact same information that you gave the practice.

First Name *

[redacted]

Last Name *

[redacted]

Date of Birth (MM/DD/YYYY) *

08/21/1975

Zip Code *

20603

4. Create a [Username and Password](#) for your portal account.

Create Username

Username should be 6 to 50 characters with no spaces and no @ sign. Letters, numbers and special characters _!\$*= allowed

Username *

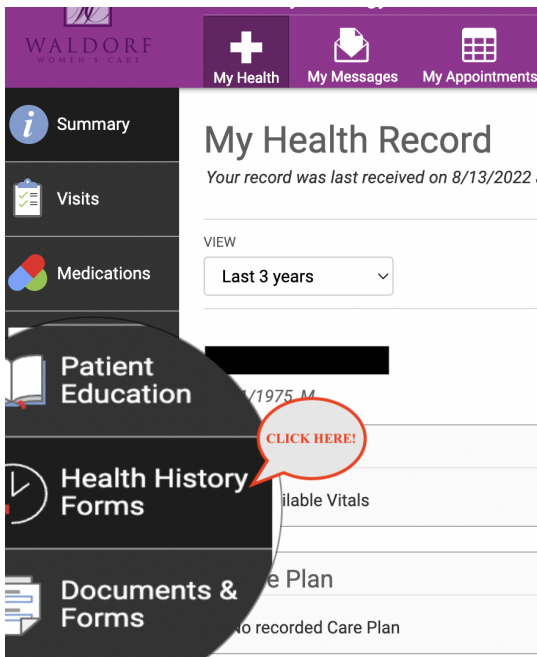
Create Password

Password should be 8-64 characters, and may include special characters. Your password should be simple enough that you can remember it without reusing or varying one of your existing passwords, and long enough that attackers can't easily guess it. Phrases or complete sentences such as, "My dog Spot is a good boy." are recommended.

Password *

Confirm Password *

5. After accept the disclaimer and login, select [Health History Forms](#) to complete your past medical history



6. Complete and submit your past medical history.

Past Medical History

The purpose of this Form is to gather your Health history. Please be as thorough as possible

Tell us about you Past Medical History.

It is very important that this section be answered completely as knowing your complete history is essential to your care.

Please provide you past medical history *

- | | |
|--|---|
| <input type="checkbox"/> *Last Colonoscopy | <input type="checkbox"/> Light or infrequent menstruation |
| <input type="checkbox"/> *Last DEXA Scan | <input type="checkbox"/> Major Depression (Recurrent) |
| <input type="checkbox"/> *Last Mammogram | <input type="checkbox"/> Menopausal Syndrome |
| <input type="checkbox"/> *Last PAP | <input type="checkbox"/> No Past Medical History |