



300 Health Park Blvd., Ste. 3002, St. Augustine, FL 32086

Phone.904.819.1500 | Fax.904.810.1023 | www.obgynstaugustine.com

Patient Registration and Insurance Information

Name: _____ D.O.B. ____/____/____ SS# ____-____-____
Address: _____
City: _____ State:____ Zip: _____
Secondary Phone: _____ Primary Phone: _____
Email Address:_____ [] decline to report

In which language do you communicate? _____

How do you prefer to be contacted? []Home phone []Cell phone []Patient Portal []standard mail

Marital Status: [] married [] domestic partner [] single [] divorced [] separated [] widowed [] unknown

In case of an EMERGENCY we have permission to contact Name:_____
Number: _____

Preferred Pharmacy: _____ Preferred Imaging Facility:_____

We are required by law to ask which RACE and what ETHNICITY best describes you (you may decline to report). Please choose one in each of the following categories

- RACE: [] American Indian or Alaska Native
[] Asian
[] Black or African American
[] Native Hawaiian or Pacific Islander
[] White
[] Other _____
[] Decline to report

- ETHNICITY [] Hispanic or Latina
[] Not Hispanic or Latina
[] Other _____
[] Decline to report

PLEASE COMPLETE ALL INSURANCE INFORMATION

If you do NOT have insurance, check here _____

Insurance Co._____ Name of insured_____

Policy holder's date of birth:_____ Relationship _____

Guarantor:_____ DOB:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical or medical benefits to OBGYN ASSOCIATES for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize OBGYN ASSOCIATES to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand I may revoke this consent at any time by notifying OBGYN ASSOCIATES in writing. OBGYN ASSOCIATES has the right to refuse treatment should I revoke or refuse this consent.

Patient Signature _____ Date _____



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Privacy Issues for Patients

I have read and understand the "Notice of Privacy Practices" which is available at the front desk. A printed copy is available upon request.

Signature: _____

Date: _____

Please list the following people that you give OB/GYN ASSOC. OF ST. AUGUSTINE permission to release your detailed medical information to. IF you choose not to release your medical information, please write NONE below.

(Please print)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____

Date: _____

Office Policies

1. Your co-pay is due at the time of service. You are responsible for any deductible insurance amounts.
2. If your insurance requires a referral or authorization, it is your responsibility to get it.
3. Your insurance company has contracted with a lab for any blood work, PAP smears or biopsies. You should know which lab to visit for blood work. We will make every attempt to send any specimens to the correct lab. Our office does not bill for lab work; the lab company will bill you for any labs, PAP smears or biopsies.
4. Our office has a \$50.00 NO SHOW fee and requires a 24 hour notice of any cancellations.
5. Balances older than 90 days are turned over to a Collection Agency and a Collection Fee will be added to your balance.
6. FMLA Paperwork Fee is \$25 for the initial set and \$10 for each additional set.

Signature: _____

Date: _____



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WELCOME TO OUR PRACTICE!

4/3/17

Name: _____ DOB : _____ Date: _____

I am here for (please check one) ANNUAL EXAM _____ PROBLEM VISIT _____ BOTH _____

Are you allergic to any medications? (Please list medication and reaction)

Blank lines for listing allergies and reactions.

Current medications (Please include birth control and herbal supplements)

Blank lines for listing current medications.

GYNECOLOGIC HISTORY

Date of last menstrual period ___/___/___ Age at onset of period _____
If menopausal, age at time of last period _____
Date of last mammogram ___/___/___ Date of last colonoscopy ___/___/___ Date of last bone density ___/___/___
Date of last Pap smear ___/___/___ Abnormal Pap? []Y []N If yes, when? ___/___/___
Have you received the HPV vaccine? []Y []N If yes, was the three shot series completed? []Y []N
Do you identify as []Heterosexual []Homosexual []Bisexual []Transgender []Other
Are you sexually active? []Y []N
Are you currently using a birth control method? []Y []N Method: _____
Do you have any history of sexually transmitted diseases? []Y []N _____
Any significant GYN history? _____

OBSTETRIC HISTORY

How many pregnancies have you had total (including miscarriages)? _____ How many deliveries? _____

Delivery History:

Table with 8 columns: Date of Birth, Full Term?, CS or Vaginal, Length of Labor, Weight, Sex, Complications? and 4 rows for delivery history.

FAMILY HISTORY

| | Diseases/Complications | If deceased, at what age? |
|----------------------|------------------------|---------------------------|
| Mother | | |
| Father | | |
| Sister(s) | | |
| Brother(s) | | |
| Maternal Grandmother | | |
| Maternal Grandfather | | |
| Paternal Grandmother | | |
| Paternal Grandfather | | |
| Other | | |

SOCIAL HISTORY

Are you a cigarette/cigar smoker? Y N Cig/day _____ Years of use _____ Are you ready to quit? Y N

Alcohol intake: (check one) never occasionally daily

Do you have a current or past history of drug use (including misuse of prescription medications)? Y N

Caffeine: Y N amount/day: _____

Exercise level: (check one) never occasionally moderate heavy

Diet: (check one) Vegan Vegetarian Gluten Free Diabetic No Restrictions

Marital Status: married domestic partner single divorced separated widowed unknown

If you are in a relationship, how long have you been with your current partner? _____

Have you ever felt threatened or unsafe in a relationship? Y N Past relationship Current relationship

Education Level: (check one) High School 2yr College 4yr College Post Graduate

Occupation: _____

Is a blood transfusion acceptable in an emergency? Y N

SURGICAL HISTORY

| Name of Surgery | Date of Surgery |
|-----------------|-----------------|
| | |
| | |
| | |
| | |
| | |

MEDICAL HISTORY (Please describe any medical conditions that apply to you)

- | | |
|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer _____ | <input type="checkbox"/> Y <input type="checkbox"/> N History of Chicken Pox _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Migraines _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hypertension _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures/Epilepsy _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dermatology _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Bone Fractures as an Adult _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes/Gestational Diabetes _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Depression/Anxiety/Psychiatric Disorder _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Asthma _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Abdominal Digestive Problems _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disorder _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Urology _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Clots/Bleeding Disorder _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Weight Management _____ |

Other :



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Name: _____

REVIEW OF SYSTEMS

In the past 1-2months have you experienced any of the following?

Constitutional

- Unexplained fever? Y N
- Night sweats? Y N
- Unexplained weight gain? Y N
- Unexplained weight loss? Y N

Ear/Nose/Throat

- Difficulty hearing? Y N
- Frequent nose bleeds? Y N
- Sore throat? Y N

Cardiovascular

- Chest pain? Y N
- Shortness of breath when lying down? Y N
- Known heart murmur Y N

Respiratory

- Persistent cough lasting >4weeks Y N
- Wheezing? Y N
- Shortness of breath? Y N

Gastrointestinal

- Abdominal pain? Y N
- Bloating? Y N
- Change in appetite? Y N

Genitourinary

- Leaking of urine (incontinence)? Y N
- Increased frequency of urination? Y N
- Blood in urine Y N

Integumentary

- Abnormal mole? Y N
- Rashes? Y N

Neurologic

- Loss of consciousness? Y N
- Change in headache pattern? Y N

Psychiatric

- Felt/feeling depressed or sad? Y N
- Sleep disturbances? Y N

Endocrine

- Heat/cold intolerance? Y N
- Excessive hair growth? Y N
- Increased thirst/hunger? Y N



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PELVIC HEALTH SURVEY

Name: _____ DOB : _____

Date: _____

BLADDER HEALTH

1. How often do you leak urine (only check one box)?

- Never (skip questions 2 & 3)
Once a week or less
Two or three times a week
About once a day
Several times a day
All the time

2. When does urine leak (check all that apply)?

- Never-Urine does not leak
Leaks before I can get to the toilet
Leaks when I cough or sneeze
Leaks even when I am asleep
Leaks when I am physically active/exercise
Leaks after I have finished urinating and get dressed
Leaks for no obvious reason
Leaks all the time

3. Overall, how much does leaking urine interfere with your daily life?

Please circle a number between 0(not at all) and 10(a great deal)

0 1 2 3 4 5 6 7 8 9 10
(not at all) (a great deal)

BOWEL HEALTH

- 1. Do you accidentally leak stool? NO YES
2. Do you strain to have bowel movements? NO YES
3. Do you pass gas when you do not want to? NO YES

OB/GYN HISTORY

- 1. Have you ever had a baby vaginally? NO YES#
2. Have you ever had a baby by Cesarean Section? NO YES#
3. If you have had a baby what was her or his weight at delivery?

lbs oz lbs oz lbs oz
lbs oz lbs oz lbs oz

4. If you have had a baby vaginally did you have a vaginal tear? NO YES

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____

Date of Birth: _____

Provider: _____

Today's Date : _____

Instructions: Please check yes for those that apply to **YOU and/or YOUR FAMILY** on both your mother's (maternal) or father's (paternal) side.

You and the following family members should be considered:

| | | |
|-----------------|----------------------------|---|
| Mother | Maternal Uncle/Aunt | Maternal Grandmother/Grandfather |
| Father | Paternal Uncle/Aunt | Paternal Grandmother/Grandfather |
| Brother | First Cousins | |
| Children | Niece/Nephew | |

(if yes then who)

| COLON and UTERINE CANCER | YES | NO | Self | Family Member | Age at diagnosis |
|--|-----|----|------|---------------|------------------|
| Uterine(endometrial) cancer before 50 | | | | | |
| Colorectal cancer before age 50 | | | | | |
| Two or more Lynch Syndrome cancers* in the same person or on the same side of the family | | | | | |

(*Lynch Syndrome cancers include: Colon, Rectal, Uterine, Ovarian, Stomach, Gall Bladder Duct, Intestinal, Pancreas and Brain)

(if yes then who)

| BREAST and OVARIAN CANCER | YES | NO | Self | Family Member | Age at diagnosis |
|--|-----|----|------|---------------|------------------|
| Breast cancer at age 50 or younger | | | | | |
| Ovarian cancer | | | | | |
| Two primary (unrelated) breast cancers in the same person or on the same side of the family | | | | | |
| Male breast cancer | | | | | |
| Triple negative breast cancer (ER-,PR-HER2-pathology) | | | | | |
| Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family | | | | | |
| Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family | | | | | |
| Have you or any member of your family ever been tested for hereditary risk of cancer | | | | | |



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ADVANCED ANNUAL NOTICE

Dear Patient,

You are scheduled for your annual pap smear, breast and pelvic examination today. Our normal fee for this service is \$160 for established patients and \$200 for new patients. Any lab work (pap smear, blood work) that may be associated with the exam will be billed by the laboratory directly. **If you have health insurance that we will be billing for you today and you do not have a benefit for this exam, you will be responsible for this fee.** The laboratory will bill you separately for those charges.

If you have other medical concerns not related to your annual exam that you would like to discuss with the doctor at the same time and it meets necessity to bill additionally for this service, we will do so. By signing this form, you are confirming your agreement to assume financial responsibility for payment of these charges should your insurance find them not medically necessary or non-covered.

Patient Signature: _____ Date: _____