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 ______________

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: ______________

OBGYN ASSOCIATES ST. AUGUSTINE
300 Health Park Blvd, Suite 3002 • St. Augustine, Florida 32086
PHONE 904.819.1500 • FAX 904.810.1023
OBGYNSTAUGUSTINE.COM

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 for an office visit and $200.00 NO SHOW FEE for an office procedure. ANY CANCELATION RECQUIRES A 24 HOUR NOTICE.

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 $25 for the initial set and $10 for any additional sets.

Signature: ______________________________ Date: ______________
4/3/17

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WELCOME TO OUR PRACTICE!

Name:____ DOB : ______________ Date:__________________

I am here for ***(please check one)*** ROUTINE GYN EXAM ________ PROBLEM VISIT _________ BOTH ________

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

____ ____
____ ____
____ ____

Current medications (Please include birth control and herbal supplements)

____ ____
____ ____
____ ____

<u>GYNECOLOGIC HISTORY</u>

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:

	Date of Birth	Full Term?	CS or Vaginal	Length of Labor	Weight	Sex	Complications?
1							
2							
3							
4							

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)

☐Y ☐N Cancer_______________
☐Y ☐N Heart Disease_______________
☐Y ☐N Hypertension_______________
☐Y ☐N Dermatology_______________
☐Y ☐N Diabetes/Gestational Diabetes_______________
☐Y ☐N Thyroid Problems_______________
☐Y ☐N Abdominal Digestive Problems_______________
☐Y ☐N Liver Disease _______________
☐Y ☐N Blood Clots/Bleeding Disorder _______________
☐Y ☐N History of Chicken Pox
☐Y ☐N Migraines_______________
☐Y ☐N Seizures/Epilepsy_______________
☐Y ☐N Bone Fractures as an Adult_______________
☐Y ☐N Depression/Anxiety/Psychiatric Disorder
☐Y ☐N Asthma_______________
☐Y ☐N Autoimmune Disorder_______________
☐Y ☐N Urology_______________
☐Y ☐N Weight Management_______________

Other :

4/3/17

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Name:______________________

REVIEW OF SYSTEMS

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

Constitutional

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

Ear/Nose/Throat

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

Cardiovascular

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

Respiratory

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

Gastrointestinal

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

Genitourinary

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

Integumentary

	Y	N
Abnormal mole?	☐Y	☐N
Rashes?	☐Y	☐N

Neurologic

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

Psychiatric

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

Endocrine

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

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***

COLON and UTERINE CANCER	*YES*	*NO*	*Self* (*if yes then who*)	*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)

BREAST and OVARIAN CANCER	*YES*	*NO*	*Self* (*if yes then who*)	*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					

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: ________________