PATIENT INFORMATION RECORD

PATIENT'S NAME: _____

LOCAL MAILING ADDRESS: _____

CITY STATE ZIP CODE

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ AGE: _____

MARITAL STATUS: (S,M,D,W): _____ RELIGION: _____ RACE: _____

EMAIL ADDRESS: _____ CELL PHONE#: _____

PATIENT'S PHONE #: _____ WORK PHONE #: _____

PLACE OF EMPLOYMENT: _____ Primary Insurance Co: _____

If your insurance is under someone else's name, please provide the following:

Subscriber's Name: _____ DOB: _____ SS# _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

CIRCLE LAB we are to use for your specimens: ***QUEST*** ***LABCORP*** ***CFHA/LRMC***

Local Pharmacy Name: _____ *Phone #:* _____

Mail Order Pharmacy Name: _____ *Phone #:* _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance or third payer within a reasonable period of time not to exceed 60 days. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

I authorize, request and assign payment directly to Lake OB-GYN Associates of Mid-Florida, LLC by all insurance carriers with whom I have coverage or from whom benefits are or may become payable to me including settlements or judgments flowing from incidents for which I may receive treatment. This assignment shall remain in effect until revoked by me in writing.

I authorize Lake OB-GYN Associates of Mid-Florida, LLC to release information or copies of all medical records, including those that may contain information related to **HIV/AIDS, sexually transmitted diseases, mental health (excluding psychotherapy notes maintained separately from my medical record), alcohol or substance abuse, and genetic testing,** which are contained in my patient file to any third party payor or their representatives for the purpose of obtaining payment for the services rendered by Lake OB-GYN Associates of Mid-Florida, LLC, or, at my request, to another medical provider for the purpose of continued care.

FOR MEDICARE PATIENTS: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Lake OB-GYN Associates of Mid-Florida, LLC for any services furnished me by Lake OB-GYN Associates of Mid-Florida, LLC. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I agree to execute such forms and documents as may be necessary to apply for and obtain payment.

I hereby acknowledge that I have received a copy of the Lake OB-GYN Associates of Mid-Florida, LLC Notice of Privacy Practices as required by Federal Law.

I hereby consent to services, treatment and diagnostic procedures, including but not limited to medications, lab tests and/or a medically indicated physical examination. This may include, but is not limited to: a gynecological exam, which may include a rectal exam and/or a pelvic exam; an ultrasound exam, which may include a probe placed in the vagina; a rectal exam; examination of external genitalia. This will be performed by Douglas Moffett, MD and/or Mitra Mossaddad, MD and/or Teresa Mendez, APRN. This consent will remain active until I withdraw my consent in writing.

_____ _____ _____

Date Patient's Signature or Personal Representative Description of Personal Representative's Authority

Lake OB-GYN ASSOCIATES of Mid-Florida, LLC

601 East Dixie Avenue, Medical Plaza #401, Leesburg, FL 34748
1400 US Hwy. 441 N., Bldg. #950, Suite #952, The Villages, FL 32159

PATIENT NAME:_____ SS#:_____ Date:_____

Birthdate:____/___/___ Age:____ Marital Status - M S D W

Primary Care Physician:_____ Referring Physician:_____

CHIEF COMPLAINT: _____

PAST MEDICAL HISTORY AND FAMILY HISTORY: Please respond by placing a check mark (✓) beside any illnesses you or your immediate family have experienced. If you do not understand the questions, leave it blank.

	Self	Family		Self	Family
Diabetes	____	____	Heart Disease	____	____
Thyroid Disease	____	____	Stroke	____	____
Cancer of the Ovary	____	____	Varicose Veins	____	____
Cancer of the Breast	____	____	Phlebitis	____	____
Cancer of the Lungs	____	____	Hypertension	____	____
Cancer of the Colon	____	____	Slow / Irregular pulse	____	____
Arthritis Bursitis	____	____	Migraines	____	____
Back pain or Sciatica	____	____	Hepatitis or Cirrhosis	____	____
Anemia	____	____	Gallstones	____	____
Tuberculosis	____	____	Colitis	____	____
Asthma/Sinus Allergies	____	____	Diverticulitis	____	____
Cholesterol	____	____	Polyps in bowel	____	____
Emphysema	____	____	Hemorrhoids	____	____
Kidney Stones	____	____	Breast Disease	____	____
Bladder Infections	____	____	Epilepsy	____	____
Glaucoma	____	____			

SOCIAL HISTORY:

Tobacco Use: __No __Yes Alcohol/Drugs Use: __No __Yes Caffeine Use: __No __Yes
Seat Belt Use: __No __Yes Domestic Violence: __No __ Yes Reg. Exercise: __No __Yes
Other:_____

First day of last menstrual cycle: ___/___/___
Menstrual cycles began at age:____
Every ____ days; Lasting ____ days

No. Of Pregnancies (ALL):_____ C-Sections?_____
Miscarriages or Abortions?_____
Birth Control Pills?_____
Menopause at what age or year?_____

Have you had a hysterectomy? YES / NO

If YES, when?_____

FOR INSURANCE PURPOSES, IS THIS YOUR:

_____A. Annual Well-Woman check-up?
Initials

_____B. Diagnostic coded Exam? (Having a problem?)
Initials

PATIENT NAME:_____ DOB:_____

REVIEW OF SYSTEMS: Do you have any of the following symptoms currently? Please respond by placing a check mark beside the symptom. If you do not understand the question, please respond with a question mark.

	YES		YES
Headaches	___	Depression/Crying	___
Dizziness	___	Night Sweats/Hot Flashes	___
Loss of Consciousness	___	Water Retention/Swelling feet	___
Mood Swings	___	Breast Mass/Soreness	___
Fatigue	___	Nipple Discharge or Bleeding	___
Muscle Weakness	___	Gas	___
Difficulty swallowing	___	Coughing up Blood	___
Indigestion/Heartburn	___	Wheezing	___
Nausea or Vomiting	___	Trouble Walking	___
Poor Appetite/Weight Loss	___	Glasses/Contacts	___
Diarrhea	___	Painful Intercourse	___
Constipation	___	Shortness of Breath	___
Blood in Bowel Movement	___	Chest Pain	___
Urinary Problems	___	Skin Rash or Itching	___
Painful Urination	___	Jaundice (Yellow Skin)	___
Blood in Urine	___	Incontinence	___

Any other problems not mentioned above:_____

**Do you have to routinely take antibiotics before visiting the dentist? YES / NO

LIST MEDICATIONS YOU USE REGULARLY:

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

ALLERGIES

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

LIST SURGERIES YOU HAD:

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

Patient's Signature:_____ Date:_____