Our Patient Portal is back!!!

Follow your Health with River City OBGYN

This secure, HIPAA-compliant patient portal allows you to see your lab results, vitals, health history, and upcoming appointments. You can also email your provider's office for prescription refills, questions concerning your health, or to request an appointment.

Steps to join:

- Our staff will send you an invite by email.
- Click on the link – If you previously had an account with NFOBGYN or any other provider, select that you have an EXISTING account to link these.
- User name will default to your email, but can be changed.
- Your invitation code will be the last 4 of your SSN.

Your email invitation will contain full instructions, but if you need additional help, you can email fmh@rcobgyn.com.

Follow and be engaged in your health!
Sign up below- You will receive an invitation in your email shortly. Keep this sheet and follow the instructions and be on your way to a convenient way to manage your health!

(Tear here)

Sign up to receive your patient portal invitation

Name_____

Date of Birth_____

Email address_____

River City OBGYN
Specialists in Women's Health

Current Date: _____

Completed by: _____

Patient Update Information

Name: _____

Address: _____

_____

Maiden Name: _____

Date of Birth: _____

SSN: _____

Race: _____

Cell Phone #: _____ - _____- _____

Home Phone #: _____ - _____- _____

Ethnicity: Non-Hispanic or Hispanic (Circle One)

Email address if over age 18:

_____

(If provided, you are consenting to email correspondence)

Marital Status: Single / Married / Divorced / Widowed

Employer: _____

Primary Care Physician: _____

Pharmacy Name **and** Location:

_____

Emergency Contact: _____ Relationship to you: _____ Phone #: _____

Primary Insurance:

Carrier: _____ Plan#: _____ Group #:_____

Subscriber Name: _____ Relationship to insured: Self / Spouse / Child

DOB of Policy Holder: _____ Policy Holder SSN#: _____ Policy Holder Employer: _____

Secondary Insurance:

Carrier: _____ Subscriber Name: _____

If the subscriber is not the patient, what is the relationship to the patient: Spouse / Parent / Or _____

DOB of Policy Holder: _____ Policy Holder SSN#: _____ Policy Holder Employer: _____

PLEASE INITIAL ONE BELOW:

- _____ I **ALLOW** River City OBGYN to discuss details of my medical records/financial records with _____ **(Print Name, Phone # and relation to you).**
- _____ I **DO NOT ALLOW** River City OBGYN to discuss details of my medical records/financial records with anyone else but myself.

I understand that I am responsible to River City OBGYN, for its customary fee for services rendered to me by River City OBGYN. I further understand and agree if I fail to make timely payments to River City OBGYN that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s). I hereby consent to and authorize the performance of all appropriate procedures, examinations including but not limited to a pelvic exam, and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I also consent to electronic access to my medication history.

For the services rendered by River City OBGYN, I authorize the release of my medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination of treatment. I authorize payment of medical benefits to the physician who submits the claim. I agree to hold River City OBGYN harmless from any and all costs, liability and damages of nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

Patient Signature: _____ Date: _____ Acct: _____

River City OBGYN

836 Prudential Drive, Suite 1103
Jacksonville, FL 32207
Phone: (904) 398-7654 Fax: (904) 398-0118

Date:_____ **(Please fill out all information to the best of your ability)**

Patient's Name:_____ DOB: _____/_____/_____ Age:_____ Race:_____

Referred by: _____ Primary Care Physician: _____

Reason for Appt:_____ Pharmacy:_____
(Local and Mail Order)

Allergy/Reaction:_____
Please list anything you are allergic to and the reaction it causes .(MEDICATION AND CONTACT ALLERGIES INCLUDED)

Medication & Dosage:_____
Vaccinations: FLU VACCINE_____ TETANUS____HEPATITIS SERIES____ HPV VACCINE____ PNUEMOVAX_____

Past Medical History: Have you ever had any of the following illnesses? Circle Yes or No.

Y N Have you ever had a blood transfusion? **Y N** Are you willing to have a blood transfusion to save your life?

Y N Ever had an abnormal Pap Smear? If yes, treatment_____ Year:_____

Y N Heart Trouble	**Y N** Osteoporosis	**Y N** Diabetes	**Y N** Gonorrhea
Y N Kidney/Bladder Problem	**Y N** Fibroids	**Y N** Blood Disorders/Clots	**Y N** Hepatitis
Y N High Blood Pressure	**Y N** Pelvic Prolapse	**Y N** Breast Discharge/Problem	**Y N** HIV
Y N Low Blood Pressure	**Y N** Depression	**Y N** Hemorrhoids	**Y N** Genital Herpes
Y N Thyroid Problem	**Y N** Endometriosis	**Y N** Anesthesia Problems	**Y N** Genital Warts
Y N Rectal Bleeding	**Y N** Seizures	**Y N** Heart Murmur/MVP	**Y N** Syphilis
Y N Stomach Trouble	**Y N** Anemia	**Y N** Antibiotic for dental work	**Y N** HPV
Y N IBS	**Y N** High Cholesterol	**Y N** Polycystic Ovarian Syndrome	**Cancer: _____**
Y N Ulcer	**Y N** Anxiety	**Y N** Chlamydia	**Other: _____**

Surgical History: Please list all surgeries including hospitalizations (not related to pregnancy).

Date	Procedure

Pregnancy History**:** ___ #OF PREGNANCIES___ #LIVE BIRTHS___#MISCARRIAGES___#ABORTIONS___#LIVING CHILDREN

Date	Delivery Type (vaginal/cesarean)	Wks	Sex	Lbs/Oz	Complications

Family History: Please list illnesses of these family members: children/mother/father/siblings/grandparents

Cancer Type	Family Member/Age
Y N Breast Cancer	
Y N Uterine Cancer	
Y N Skin Cancer	
Y N Ovarian Cancer	
Y N Colon Cancer	

Y N Heart Disease. Who?_____
Y N High Blood Pressure. Who:_____
Y N High Cholesterol. Who?_____
Y N Blood Disorder. Who?_____
Y N Diabetes. Who?_____
Y N Thyroid Disease. Who?_____

Other Significant Family History:_____

Social History

Marital History: Single/Married/Separated/Divorced/Widowed

Use of alcohol:
Never/Daily/Moderate/Social/Rare

Use of tobacco: **Never/Current/Past ____ ppd**

Use of drugs: **Never/Past/Current**

Hx of domestic violence: **Y N**

Sexually active: **Y N** Birth control method:_____

1st Day of Last Period:_____ Cycle Length: _____days # of days bleeding _____ Flow: light/ moderate/heavy

Last Pap:_____ Last Mammogram:_____ Last Bone Density:_____ Last Colonoscopy:_____

Medication and Allergy List

Name:_____ DOB:_____

Name of Medication	Dosage	How Often Taken	Last Time Taken

- List other medications you are allergic to including all over the counter medications and herbal supplements.
  (Excluding the allergies listed on previous pages)

Allergic to:	Reaction:

Please also list allergies to environment, insects, shellfish, dyes, etc.

River City OBGYN
Specialists in Women's Health

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Satellite ▪ 9889 Gate Parkway ▪ Suite 205 ▪ Jacksonville, FL 32246
Phone (904) 398-7654 ▪ Fax (904) 398-0118

Dear Patient,

In the event we prescribe narcotics, diet pills, sedatives, muscle relaxers, or other controlled substances for you, you are required by law to inform us of any other controlled substances which you have recently been prescribed or received from any other doctor. In general, this would include the prior six months period. Failure to provide this information will result in discontinuation of further controlled substances from our office and may have other legal implications for you.

Thank you for your assistance and compliance.

Your signature below acknowledges that you have read the above notice and have complied with these guidelines.

_____	_____	_____
Patient Name Printed	Date of Birth	Acct #

_____	_____
Patient Signature	Date

_____	_____
Witness	Date