VOLUSIA OBSTETRICS AND GYNECOLOGY

Name _____ Age _____ Date of Birth _____

Mailing Address _____

City _____ St _____ Zip_____

Home Phone _____ Driver's Lic#_____ SS# _____

Work Phone _____ Ext _____ Cell Phone _____ Race _____

Primary Physician _____ Referred by _____

Spouse's Name _____ Spouse's Date of Birth _____

Phone # best to reach you _____ Able to leave a detailed message at this # Y / N

Email _____

Pharmacy(Name/Intersection/Town)_____

Emergency Contact _____ Relation _____Phone _____

PATIENT'S EMPLOYMENT:

Employer _____

Address _____ City _____ St _____ Zip_____

INSURANCE INFORMATION:

Insurance Company _____ Policy Holder_____

Policy Holder SS # _____ Date of Birth _____

ID or Policy # _____ Group # _____

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MUST BE SIGNED:

RELEASE OF INFORMATION, BENEFIT ASSIGMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE STATEMENT AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I hereby authorize Volusia OB/GYN to release information necessary to process my insurance/Medicare claim, acquired in the course of my examination or treatment; to allow a photo copy of my signature to be used to process my insurance/Medicare claim for period of LIFETIME. I claim any insurance benefits due to me for services rendered by Volusia OB/GYN and authorize and direct my carrier to issue payment check (s) directly to Volusia OB/GYN regardless of insurance benefits, if any. I understand that I am fully financially responsible for all fees incurred, and I agree to pay such fees in full. The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose of pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges, as a result of non-payment by a carrier.

Should I be a Medicare patient, I have been informed that Medicare covers routine exams once every two years. I understand that should my insurance company deny my claim for this reason, I will be responsible for the cost of today's visit. Visits for annual exams and pap smears will be coded as such. We cannot change diagnosis codes after a visit, nor can we alter rates.

I have also been informed that should I require services in addition to my routine exam, there may be an office visit charge as well as the fee for the exam. Please also be aware it is the patient's responsibility to know which lab is participating with your insurance. After consent is obtained, if orders are sent to incorrect lab the bill will be that patients responsibility.

Signed_____ Dated_____

Patient:_____Age:_____Date:_____

REVIEW OF SYSTEMS

Do you currently have any issues with the following systems? Circle Y for yes or N for no

General Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other		

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other		

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Other		

Endocrine

Excessive Thirst	Y	N
Too hot/cold	Y	N
Tired/Sluggish	Y	N
Other		

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Hrtburn	Y	N
Other		

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Other		

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent	Y	N
Other		

Muscoloskeletal

Joint Pain	Y	N
Knee Pain	Y	N
Back Pain	Y	N
Other		

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other		

Genitourinary

Urinary Incontinence	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Other		

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Other		

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting probs	Y	N
Other		

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other		

Psychiatric

Are you happy with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Is there anyone in your home hitting or hurting you?	Y	N

Last pap smear/was it normal?_____ Any allergies?_____

Last colonoscopy/was it normal?_____ First day of last period?_____

Last mammo/was it normal?_____ Year of menopause_____or year of hyst_____

Last Bone Density Scan/was it normal?_____ Last lab work?_____

Primary care Doctor?_____ Dermatologist? _____

Any new surgeries?_____ Any new hospitalizations?_____

Have you completed the HPV vaccine series?_____

Alcohol/how much/often?_____ Caffeine/per day?_____

Smoking/per day?_____ Do you exercise?_____Contraceptive Method:_____

Family medical history:_____

Please list **ALL** medications, including vitamins, with strengths & frequency:_____

_____

Are you currently sexually active? _____ if so, with men, women or both?_____

Have you had a flu vaccination this year?_____ if not are you interested in having one?_____

Acknowledgement of Receipt
Notice of Patient Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient / Legal Representative Signature	Print Patient / Legal Representative Name	Date	Employee Initial
_____	_____	_____	_____

Acknowledgement NOT obtained because:

_____ Patient or Legal Representative declined Notice of Patient Privacy Practices.

_____ Other (briefly describe) _____

_____

_____
Employee Signature

Please list anyone with who we are able to discuss your care, finances, etc.

Name	Relationship
_____	_____
_____	_____
_____	_____

CONTRACEPTION:

When are you planning on having another child? (please check one)

___ Within the next year ___ Within the next 5 years

___ Within the next 10 years ___ I am done having children

MENSTRUAL PERIOD:

1. Do you ever feel as though your periods impact the quality of your life? ___ Y ___ N
2. Do you ever experience irregular or inconsistent bleeding patterns? ___ Y ___ N
3. Age period started _____, how often-every _____ days, length of period _____.

URINARY HEALTH:

1. Do you ever leak urine when you cough, laugh or sneeze? ___ Y ___ N
2. Do you ever feel as though you have to urinate urgently? ___ Y ___ N
3. Do you feel like you have to urinate too frequently? ___ Y ___ N
4. Do you ever experience painful urination? ___ Y ___ N