ANNUAL UPDATE INFORMATION FORM

PAITENT'S NAME: _____
First **Last (as it appears on insurance card)**

DATE of BIRTH: _____

Marital Status: S M W D

Patient's Address: _____

City: _____ State:_____ Zip: _____

Patient Home Phone: (_____) _____ - _____ Patient Cell Phone: (_____) _____ - _____

Patient Work Phone: (_____) _____ - _____ EXT: _____ (Circle preferred method of contact)

Email Address: _____

Pharmacy Name: _____ **Phone: (_____) _____ - _____**

Primary Care Physician: _____ **Phone: (_____) _____ - _____**

IN CASE OF AN EMERGENCY, NOTIFY: _____
Relationship to patient: _____ **Cell: (_____) _____ - _____**

Billing and Insurance:
Insurance Company
ID#
INSURED NAME
INSURED'S DOB

I understand the importance of current billing information and know it is my responsibility to keep this office informed of any changes in my insurance company or personal billing address. I realize any claims that are denied or delayed for timely filing due to this information not being updated are my responsibility. By signing below, I verified the information above is correct and current as of the date indicated.

PHI (PROTECTED HEALTH INFORMATION) DISCOSURE
We cannot discuss your protected health information (PHI) with anyone than yourself unless you authorize us to do so. Please list below the name(s) of the individual(s) you authorize our office to discuss your care with. Your PHI will be disclosed to the individual(s) listed below until you notify us otherwise in writing.

1._____ 2._____

This authorization will remain in effect for one year unless otherwise specified. I understand this authorization extends to all or any part or my medical records. I expressly consent to the release of the information above. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained.

By signing this official document I have read and understand the ANNUAL UPDATE INFORMATION and agree to all of its standards.

Signature: _____ **Date:** _____

Gentle Gynecology & Obstetrics

Michael F. Augustino, M.D., F.A.C.O.G.
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Consent for Voice and Text Messaging Communication

In an effort to relay **Normal results** faster to our patients we have implemented Electronic Medical Records. I understand that in order for Gentle Gynecology & Obstetrics to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to Gentle Gynecology & Obstetrics.

I further understand that in order for Gentle Gynecology & Obstetrics to text detailed messages containing specific medical information to my cell phone I need to give my written express permission to Gentle Gynecology & Obstetrics.

I also understand that my healthcare information at Gentle Gynecology & Obstetrics is protected and a copy of the Notice of Privacy Practices is available upon my request.

Consent for Messages:
I give my written express consent to Gentle Gynecology & Obstetrics to leave detailed messages on my voicemail/answering machine about my **NORMAL** lab, ultrasound, breast imaging, prescription information, reminders or Pap smear results. I also give my written express consent that this information may be communicated to me via Text message.

I understand that "sensitive" information as noted below will be excluded.

- **No abnormal results** will be communicated via our automated system.
- **No HIV results** are disclosed by phone, mail, email or text. HIV results are only given in person to the patient as stipulated by H.I.P.P.A. Law.

Patient Name (Please Print)

Patient Signature

Date

Cell: (This number will be used for messaging)

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time.

I understand that I must provide written notice to Gentle Gynecology & Obstetrics in order to revoke this consent.

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Height:

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates(Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason	Date

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details: _____

Check-In by

Name _____ Gender _____ Age _____

Date of Appointment: _____

OBGYN History

Have you ever had or do you currently have any of the following?

- ☐ Abnormal Vaginal Bleeding
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Breast Cancer
- ☐ Breast Surgery
- ☐ Cervical Cancer
- ☐ Chlamydia
- ☐ Colposcopy
- ☐ Cryosurgery
- ☐ DES Exposure
- ☐ Extreme Menstrual Pain
- ☐ Fibroids
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ Herpes
- ☐ Hot Flashes
- ☐ HPV
- ☐ Infertility
- ☐ Irregular Periods/Bleeding
- ☐ Nipple Discharge
- ☐ Ovarian Cysts
- ☐ Ovarian Cancer
- ☐ Painful Intercourse
- ☐ Pelvic Inflammatory Disease
- ☐ Uterine Cancer
- ☐ Urinary Incontinence
- ☐ Yeast Infections – Frequent

Pregnancy History

Please describe any pregnancies you have had.

# of Pregnancies _____ # of Full Term _____ # of Miscarriages _____ # of Abortions _____

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living

Were there any complications associated with any of your pregnancies?

Are you currently pregnant?

☐ Yes ☐ No

Are you trying to become pregnant?

☐ Yes ☐ No

Do you need birth control or contraceptive advice?

☐ Yes ☐ No

What method of birth control do you use?

Menstrual History

When was the first day of your last period?

How often does your period occur?

How long does your period last?

Is your period regular?

☐ Yes ☐ No

What age were you when you had your first period?

What age were you at menopause?

Health Exams & Procedures

Please check and date all immunizations you have had.

	Month & Year	Results
☐ Blood Sugar-Fasting		
☐ Breast Self Exam		
☐ Cholesterol Test		
☐ Colonoscopy		
☐ CT/CAT Scan		
☐ Dexascan (Bone Density)		
☐ EKG		
☐ Echocardiogram		
☐ Fecal Occult Blood Test		
☐ Mammogram		
☐ MRI		
☐ Pap Smear		
☐ Physical Exam		
☐ Cardiac Stress Test		
☐ Ultrasound		

Check-In by _____