Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)
Sex	Marital Status	Date of Birth	Social Security Number
Patient's Address		City	State / Zip
Home Phone		Mobile Phone	Email Address
Referred by		Primary Care Physician	Primary Care Physician Phone
Pharmacy	Pharmacy Phone	Pharmacy Address	

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone
Employer/School Address	City	State / Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	
Insured's Name(as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number
Insured's Address		City	State / Zip
Insured's Social Security Number	Insured's Birthdate		

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name(as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)		Phone	Relation to Patient
Address		City	State / Zip

Notice of HIPPA practices acknowledgment: I have read and understand the Notice of Privacy Practices.

I herby authorize Dr. Fabienne Achille or Staff to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim. I also authorize the Physicians Dr Fabienne Achille or Staff to obtain medical records from other facilities or Physicians for my continued medical care. This may include but is not limited to the following reports; Pap smear, pathology, pelvic sonograms, breast imaging, Obstetrical imaging specialist reports, and laboratory results that may include H.I.V. results & diagnosis. This release is valid for 1 year from signature.

_____ _____

Signature of Patient or Authorized Guardian Date

Check-In by

PATIENT REGISTRATION

PHI (PROTECTED HEALTH INFORMATION) DISCLOSURE
We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list 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 of my medical records. I expressly consent to the release of information as designated above. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained.

RELEASE OF MEDICAL RECORDS
If you wish to release your records to yourself, another physician, or someone else, **you must sign a release**. We will process the request and most requests are handled within ten (10) business days. (fees may apply… see the release of records form for more information.

BY INITIALING AND SIGNING BELOW YOU CONFIRM THAT YOU HAVE READ THIS POLICY AND UNDERSTAND THAT:

INSURANCE AUTHORIZATION, RELEASE, AND ASSIGNMENT OF BENEFITS
I hereby authorize Dr.Achille to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested the medical service of Dr. Achille on the behalf of myself and/ or my dependents, and I understand by making this request, I become fully financially responsible for any and all charges that occurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, insurance, and any other health/medical plan to issue payment directly to Dr. Achille for medical service rendered to myself and/ or my dependent regardless of my insurance benefits, if any.

I UNDERSTAND THAT NOT ALL SERVICES ARE COVERED BENEFITS AND I AM RESPONSIBLE FOR ANY AMOUNT NOT PAID, REGARDLESS OF INSURANCE POLICY.
INITIALS_____

I have not elected to carry medical malpractice insurance or otherwise demonstrate financial responsibility. However, I agree to satisfy and adverse judgments up to the minimum amounts pursuant to s-458.320 (5) (g). Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant
to Florida law.

INITALS_____

- It is your responsibility to inform our office of any address or telephone number changes. Your account is to be kept current accordingly, all self-pay or insurance co-payments, co-insurance, and deductibles will be collected **at the time of services. Payable by: cash, check, Visa, MasterCard, and Discover.**
- If you do not have payment(s), your appointment may be rescheduled.
- A returned check will result in a $35 service charge **and** all future payment being required in the form of CASH or CREDIT CARD
- **The first request for completion of paperwork is FREE and all others after the fact will cost a $10 FEE FOR EACH FORM (ex: Disability, FMLA, etc…)**

INITALS_____

- If unable to keep your appointment, please notify us **24 hours** in advance so that we may offer that time to another patient. A pattern of repetitive **"no show" or late cancelations may regretfully result in an assessment of a cancelation/no show fee of $50 for each incident.**
- If your insurance policy requires a referral from your primary care physician, it is your responsibility to have the referral faxed to our office prior to your appointment.

I have read and understood the above Financial Policy and agree to meet all financial obligation

Signature (Patient's Parent/Guardian, if a minor) _____ **Date** _____

Fabienne Achille, MD., F.A.C.O.G

Consent for Voice and Text Messaging Communication

To relay **Normal results** faster for our patients we have implemented Electronic Medical Records. I understand that for Dr.Achille to leave detailed messages containing specific medical information on my voicemail or answering machine. I need to give my permission to Dr.Achille and Staff.

I further understand that for Dr.Achille to text detailed messages containing specific medical information to my cell phone I need to give my written express permission to Dr.Achille/Staff.

I also understand that my healthcare information at the practice 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 the practice (Dr.Achille and Staff) 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 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 the **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 the practice (Dr.Achille/Staff) to revoke this consent.

600 N. Hiatus Road, Suite 105 • Pembroke Pines, FL 33026
• Phone (954)-833-2026 •
Fax (954)-833-2027

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 _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

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 _____

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 _____

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