# 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:_____

NAME:_____ DATE:_____

*Last* *First* *Middle*

Total Pregnancies:___ Abortions:___ Twins:___ Living Children:___ Date of Last Period:_____ Monthly Periods: YES / NO Birth Control at conception: YES / NO

PAST PREGNANCIES (Last Five):

| DOB | Gestation Weeks | Length of labor | Birth Weight | Sex M / F | Type of delivery | Anesthesia | Place of Delivery | Preterm Labor Yes/No |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**GENETIC SCREENING/TERATOLOGY COUNSELING (Includes Patient, Baby's Father, or anyone in EITHER family with:**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| 1. Patient's age 35 years or older as of estimated date of delivery | | | 12. Huntington's Chorea | | |
| 2. Thalassemia (Italian, Greek, Mediterranean, or Asian background): MCV less than 80 | | | 13. Mental retardiation/Autism | | |
| 3. Neural tube defect (Meningomyclocele, Spina Bifida, or Anencephaly) | | | If Yes, was person tested for Fragile x? | | |
| 4. Congenital Heart Defect | | | 14. Other inherited genetic or chromosomal disorder | | |
| 5. Downs Syndrome | | | 15. Maternal metabolic disorder (eg, Type 1 diabetes, PKU) | | |
| 6. Tay-Saclis (Ashkenazi Jewish, Cajun, French canadian) | | | 16. Patient or baby's father had a child with birth defects not listed above | | |
| 7. Canavan Disease (Ashkenazi Jewish) | | | 17. Recurrent pregnancy loss, or a stillbirth | | |
| 8. Familial Dysautonomia (Ashkenazi Jewish) | | | 18. Medication (including supplements, vitamins, herbs or OTC drugs) illicit/recreational drugs/alcohol since last menstrual period) | | |
| 9. Sickle Cell disease or Trait (African) | | | 19. Muscular Dystrophy | | |
| 10. Hemophilia or other blood disorders | | | 20. Any other? | | |
| 11. Cystic Fibrosis | | | | | |

**INFECTION HISTORY:**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Live with someone with TB or exposed to TB? | | | Hepatitis B, C? | | |
| Patient or partner has history of genital herpes? | | | History of STD, Gnorrhea, Chlamydia, HPV, HIV, Syphilis? | | |
| Rash or viral illness since last menstrual period? | | | If Yes, list which ones? | | |

COMMENTS:_____