MAETOZO TOTAL WOMAN'S CARE OF ST. AUGUSTINE, LLC

1301 PLANTATION ISLAND DR. STE 103 ST. AUGUSTINE, FL 32080

PH: 904.461.5330

FAX: 904.461.5334

Patient Demographics

Patient Name	Home Phone
Home Address	Work Phone
City State ZIP	Cell Phone
Date of Birth Age	Email Address
Occupation	Social Security Number
Employer	Marital Status
Work Address	City State ZIP
Referred By	Primary Language Spoken

Spouse/Emergency Contact

Name	Date of Birth
Relationship to Patient	Phone Number

Primary Insurance Information

Primary Insurance Name	Insurance Phone Number
Member/Subscriber ID	Group Number
Name of Subscriber	Subscriber's Date of Birth
Relationship to Patient	Work Phone Number

Secondary Insurance Information

Primary Insurance Name	Insurance Phone Number
Member/Subscriber ID	Group Number
Name of Subscriber	Subscriber's Date of Birth
Relationship to Patient	Work Phone Number

Release of Information

I authorize the release of any medical information necessary to process a claim.	
Signed by Subscriber	Date

Assignment of Benefits

I authorize payment of medical benefits to myself or the name provider for professional services rendered.	
Signed by Subscriber	Date

Pharmacy Information

Name of Pharmacy	Pharmacy Phone Number
Pharmacy Address	

Heath History Intake Form: Today's Date: _____

Patient Name: _____ First Date of Last Menstrual Period: _____

What Brings you in office today? _____

Primary Care Physician: _____

Preferred Pharmacy: _____ Location: _____

Please Circle Yes or No in response to the questions below:

Good general health lately?	Yes	No	Cough	Yes	No
Recent weight loss/gain	Yes	No	Asthma or wheezing	Yes	No
Heat or Cold Intolerance	Yes	No	Shortness of Breath	Yes	No
Excessive thirst or urination	Yes	No	Loss of appetite	Yes	No
Diabetes	Yes	No	Change of Bowel Habits	Yes	No
Sinus Problems	Yes	No	Blood in stool/Black stool	Yes	No
Thyroid disease	Yes	No	Stomach Ulcer	Yes	No
Depression	Yes	No	Abdominal Pain	Yes	No
Anxiety	Yes	No	Bloating	Yes	No
Chest Pain/Heart Attack	Yes	No	Liver Disease	Yes	No
High Blood Pressure	Yes	No	Difficulty Walking	Yes	No
High Cholesterol	Yes	No	Stroke Head Injury	Yes	No
Headaches or migraines	Yes	No	History of Blood Clot Lung/Leg	Yes	No
Frequent/Painful Urination	Yes	No	Leakage or dribbling of urine	Yes	No
Blood in urine	Yes	No	Autoimmune Disorders	Yes	No

Past Medical History: _____

_____

_____

Surgical History: _____

_____

_____

Current medications including Over the Counter with dosage:

_____

_____

_____

Allergies to Medications: _____

Latex Allergy: Yes No

Food Allergy: No _____

GYN History:

Vaginal Discharge?	Yes No	How Long
Sexual difficulties?	Yes No	What Type
History of STD?	Yes No	HERPES WARTS HSV 1 or 2
History Of Ovarian Problems?	Yes No	What Type

History of Breast Surgery?	Yes No	What Type
Painful Periods?	Yes No	Symptoms
Irregular Periods?	Yes No	What Type
History of Abnormal Pap Smears	Yes No	ASCUS LSIL HPV
Currently Sexually Active	Yes No	With Male or Female
Age became Sexually Active		
Total of Sexual Partners in Last year		
Current Method of Contraception		Pills IUD Vasectomy Tubal other
Age of First Cycle		
Age of Menopause		
History of Endometriosis	Yes No	When diagnosed
History of PCOS	Yes No	When diagnosed
History of Fibroids	Yes No	When diagnosed
Have you had the Gardasil Vaccine	Yes No	

Test	Date	Results if known
Last Pap		
Last Mammo		
Last DEXA		
Last Colonoscopy		
Ever Have a Pelvic Ultrasound		
Ever Have a Thyroid Ultrasound		

Pregnancy History:

Total number of pregnancies: _____ Vaginal or Csection?

Number of children: _____ Miscarriages: _____ Termination's: _____

Relationship	Diagnosis	Age at diagnosis
Mother		
Father		
Maternal Grandma		
Maternal Grandpa		
Paternal Grandma		
Paternal Grandpa		
Other Family Member:		

Social History:

Do you smoke: Yes No How Many Packs Per Day/Year: _____ Alcohol intake: Yes or No

Illicit Drug Use: Yes or No Exercise: Yes or No How Often: _____ /Week What Type: _____

Diet: regular vegetarian vegan gluten free non-specific Marital status: _____

History domestic violence or sexual abuse: _____ Current Occupation: _____

Would you accept a blood transfusion in case of an emergency? YES NO

Patient Signature: _____ Date: _____

Maetozo's Total Woman's Care of St. Augustine, LLC

Well Woman Annual Exam Consent

It is our understanding that your appointment today is for an Annual Well Woman Exam. This exam includes a breast exam, pelvic exam and pap smear (if indicated).

This preventative exam does not include treatment for a problem. If you are experiencing a problem and the provider has time to address it outside of the routine visit, there will be an additional office charge and/or copay. If there is not sufficient time to adequately address additional issues, you will be scheduled for a visit on a different day.

Some insurance policies do not cover preventative care. If your insurance company denies your visit, you will be responsible for today's charges.

Please sign below indicating that you have read and understand the above consent.

_____ _____

Patient Name Date

_____

Patient Signature

_____ _____

Staff Signature Date

MAETOZO TOTAL WOMAN'S CARE OF ST. AUGUSTINE, LLC

1301 PLANTATION ISLAND DR. STE 103
ST. AUGUSTINE, FL 32080
PH: 904.461.5330
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I, (please print) _____

Authorize Maetozo Total Woman's Care of St. Augustine, LLC

To release or discuss information related to my medical condition (including information related to my treatment plan, medication information, and/or billing information) the following persons.

1) _____

2) _____

3) _____

Please be advised that any person not referred to on this list will not be given any information related to your care, including billing information. You may change, restrict, or expand this listing at any time.

You are not required to list any name, if you do not so choose.

_____ _____

Signature Date

MAETOZO TOTAL WOMAN'S CARE OF ST. AUGUSTINE, LLC

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Patient Consent for E-Prescribing

I have been made aware and understand that the medical practice may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy.

I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers.

I give consent to my provider to see this protected health information (PHI).

_____ _____

Signature Date

AUTHORIZATION TO RELEASE HEALTH INFORMATION

PLEASE PRINT CLEARLY

PATIENT NAME: _____

ADDRESS: _____

PHONE: _____BIRTHDATE: _____

I AUTHORIZE: ***MAETOZO TOTAL WOMAN'S CARE OF ST. AUGUSTINE***
1301 PLANTATION ISLAND DRIVE, SUITE 103
ST. AUGUSTINE, FL 32080
PHONE 904-461-5330 - FAX 1-855-279-4391

_____ Receive my records from

_____ Release my records to

NAME OF DOCTOR, HOSPITAL, ETC _____

ADDRESS _____

CITY/STATE/ZIPCODE _____

PHONE # _____FAX # _____

FOR THE PURPOSE OF REVIEW/EXAMINATION, I FURTHER AUTHORIZE YOU TO PROVIDE SUCH COPIES THEREOF AS MAY BE REQUESTED. THE FORGOING IS SUBJECT TO SUCH LIMITATION AS INDICATED BELOW:

( ) ENTIRE RECORD

( ) SPECIFIC INFORMATION _____

REASON FOR REQUEST _____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE SIGNED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. I DO EXPRESSLY AND VOLUNTARILY CONSENT TO THE DISCLOSURE OF THE INFORMATION CHECKED ABOVE TO THE PERSON/DOCTOR/AGENCY NAMED ABOVE. I UNDERSTAND THAT IF THE PERSON(S) AND/OR ORGANIZATION(S) LISTED ABOVE ARE NOT MANDATED BY THE FEDERAL PRIVACY STANDARDS, THE HEALTH INFORMATION DISCLOSED AS A RESULT OF THIS AUTORIZATION MAY BE REDISCLOSED WITHOUT MY AUTHORIZATION. I UNDERSTAND THAT I MAY BE CHARGED A FEE FOR COPYING THESE MEDICAL RECORDS.

SIGNED _____DATE _____

WITNESS _____