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_____

MENSTRUAL History: Age periods began _____ First day of last period _____/_____/_____

Periods every _____ days. Was this a normal period? Y / N

If no, explain _____

OBSTETRICAL History: Number of total pregnancies _____ Live Births _____

Miscarriages _____ Abortions _____ Premature Births _____

Age of children _____ Comments: _____

CONTRACEPTIVE History: Current Method _____

List all methods (used formerly & length of use) _____

ALLERGY History: Please list all medication allergies: _____

MEDICAL History:

		YEAR			YEAR			YEAR
Anemia	Y/N	_____	Seizures	Y/N	_____	Stroke	Y/N	_____
Migraine Headache	Y/N	_____	Diabetes	Y/N	_____	Arthritis	Y/N	_____
High Blood Pressure	Y/N	_____	Heart Failure	Y/N	_____	Alcohol	Y/N	_____
Heart Attack	Y/N	_____	Rheumatic Fever	Y/N	_____	Asthma	Y/N	_____
High Cholesterol	Y/N	_____	Stomach Ulcers	Y/N	_____	Colitis/IB	Y/N	_____
Lung Disease	Y/N	_____	Liver Disease	Y/N	_____	Cancer	Y/N	_____
Hepatitis A,B or C	Y/N	_____	Urine Incontinence	Y/N	_____	Phlebitis	Y/N	_____
Bladder Infection	Y/N	_____	Thyroid Disease	Y/N	_____	Lupus	Y/N	_____
Kidney Disease	Y/N	_____	Sickle Cell	Y/N	_____	Anxiety	Y/N	_____
Blood Transfusions	Y/N	_____	Stroke	Y/N	_____	Depression	Y/N	_____
						Other mental conditions	Y/N	_____

Do you smoke? Y / N If yes, how many packs a day? _____

GYNECOLOGICAL History:

		YEAR			YEAR			YEAR
DES Exposure	Y/N	_____	Abnormal Pap	Y/N	_____	Chlamydia	Y/N	_____
Recurrent Vaginitis	Y/N	_____	Pelvic Infections (PID)	Y/N	_____	Gonorrhea	Y/N	_____
Endometriosis	Y/N	_____	Chronic Pelvic Pain	Y/N	_____	PMS	Y/N	_____
Pain w/Intercourse	Y/N	_____	Fibroid Tumors	Y/N	_____	Herpes	Y/N	_____
Condyloma (warts)	Y/N	_____	Ovarian Cysts	Y/N	_____	AIDS/HIV	Y/N	_____
Urinary Incontinence	Y/N	_____	Pelvic Pressure	Y/N	_____	Infertility	Y/N	_____
Recurrent Miscarriage	Y/N	_____	Cervical Cancer	Y/N	_____	Breast Pain	Y/N	_____

SURGICAL History: Please list all surgical procedures and their year _____

FAMILY History: Any family history of heart disease, cancer, mental problems, diabetes, breast or gynecological problems? If yes, List who and what problems: _____

MEDICATION History: Please list <u>ALL</u> medications with strength and dosage: _____

VOLUSIA OBSTETRICS AND GYNECOLOGY
500 HEALTH BLVD ~ DAYTONA BEACH, FL 32114
Phone 386-252-5858 Fax 386-252-4477

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CONSENT FOR TREATMENT

With any medical treatment, there is some risk involved. I hereby give consent to Volusia Obstetrics and Gynecology to provide and perform any medically indicated examination and treatment including but not limited to a pelvic exam for the below mentioned patient.

The consent will remain active until I withdraw my consent in writing.

_____ _____
Patient/Responsible Party *Date*

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CONSENT FOR TREATMENT OF MINOR

I hereby authorize Dr. _____ or his/her staff to examine and/or treat as described above.

_____
Relationship

_____
Full name of child

_____ _____
Responsible Party *Date*

_____
Witness

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
Name	Relationship
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

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			Eyes			Neurological		
Fever	Y	N	Blurred Vision	Y	N	Tremors	Y	N
Chills	Y	N	Double Vision	Y	N	Dizzy Spells	Y	N
Headache	Y	N	Pain	Y	N	Numbness/Tingling	Y	N
Other			Other			Other		

Endocrine			Gastrointestinal			Cardiovascular		
Excessive Thirst	Y	N	Abdominal Pain	Y	N	Chest Pain	Y	N
Too hot/cold	Y	N	Nausea/Vomiting	Y	N	Varicose Veins	Y	N
Tired/Sluggish	Y	N	Indigestion/Hrtburn	Y	N	High Blood Pressure	Y	N
Other			Other			Other		

Integumentary			Muscoloskeletal			Ear/Nose/Throat/Mouth		
Skin Rash	Y	N	Joint Pain	Y	N	Ear Infection	Y	N
Boils	Y	N	Knee Pain	Y	N	Sore Throat	Y	N
Persistent	Y	N	Back Pain	Y	N	Sinus Problems	Y	N
Other			Other			Other		

Genitourinary			Respiratory			Hematologic/Lymphatic		
Urinary Incontinence	Y	N	Wheezing	Y	N	Swollen Glands	Y	N
Painful Urination	Y	N	Frequent Cough	Y	N	Blood Clotting probs	Y	N
Urinary Frequency	Y	N	Shortness of Breath	Y	N	Other		
Other			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?_____