DAVID I. LUBETKIN, MD, FACOG
NICOLE TENZEL,MD
Obstetrics · Gynecology · Infertility

COURTNEY McMILLIAN, CNM, APRN
NICOLE DARBY RAMIREZ, CNM, APRN

Patient Name: ______________________________ DOB ______________

Address ____

City____________________ State ______________ Zip Code______________

Phone # (   )____________________ Alt # (   ) ____________________

Primary Language ______________ Race ________________ Ethnicity__________

Pharmacy Name, Location & Phone #: ______________________________

____

Referred by ____

Email Address ____

Financial Statement

I certify that the above information is correct and further authorize any holder of medical information to be released to any insurance carrier for any claim. I request payment of authorized benefits for physician services to the physician furnishing the service or authorize such a physician to submit a claim for me. I also agree that should this account be referred to any agency or attorney for collection that I will be responsible for all collection fees, attorney fees and court costs. I am also aware that payment is expected when services are rendered unless other arrangements have been made in advance.

The office will bill your insurance. The insurance plan will determine benefits once the claim is received. I understand that if my insurance is accepted that it will be billed and I will be responsible for any deductible, copay, and coinsurance. I will also be responsible for any fees that are not covered by my insurance. I understand that it is my responsibility to provide valid insurance at the time of my visit, or I will be responsible for the full amount of the services rendered.

Signature______________________________________ Date ______________

1001 NW 13th Street, Suite 101A
Boca Raton, FL 33486
Phone (561) 300-0600 · Fax (561) 300-0601

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Notice of Privacy Acknowledgement

I understand that under 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 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. I authorize the following people to speak to the office regarding my health information:

Name ______________________________ Relationship ______________________

Name ______________________________ Relationship ______________________

Signature ______________________________________ Date: ______________

Malpractice Statement

Under Florida Law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **Dr. Lubetkin has met these requirements and has decided to become self-insured and not carry commercial medical malpractice insurance**. This is permitted under Florida Law subject to certain conditions. Florida law imposes penalties against non insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida law title XXXII Chapter 458.320. The undersigned patient, spouse and/or legal guardian or parents acknowledges that she/he has received a copy, read and understands this Medical Malpractice Insurance notice. Furthermore, the undersigned acknowledges this notice was not signed under duress and that all of the patient's questions relating heretofore have been answered to the patient's satisfaction.

Patient name ______________________________________ Date: ______________

Signature ____

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Consent for Pelvic Exam

Patient Name: ____

DOB ______________________

I hereby request and authorize David Lubetkin, MD; Nicole Tenzel, MD; Courtney McMillian, CNM; and/or Nicole Darby Ramirez, CNM to perform a pelvic examination. I understand a pelvic exam may be performed as part of my routine or wellness checkup to monitor for possible signs of ovarian cysts, sexually transmitted infections, uterine fibroids or early stage cancer and are routinely done during pregnancy checkups. Pelvic exams are also performed to investigate symptoms such as abnormal bleeding, unusual vaginal discharge, or pain.

I further understand the pelvic exam includes an external and internal assessment of my genitourinary system including the vulva, vagina, uterus, ovaries, fallopian tubes, the bladder and the rectum. This involves visual examination of the external genitalia and internal visual exam of the vaginal walls and cervix using a metal speculum (device to open the vaginal canal). A small sample of cells from the cervix may be taken for a Pap test. To complete the exam, bimanual palpation or touching of the size and shape of the pelvic organs is conducted by inserting two fingers into the vagina and pressing with the other hand on the abdomen, possibly followed with a rectal exam. While there may be some minor discomfort, a pelvic exam should not be painful.

By signing the document below, the patient or responsible party listed above consent to a **medically indicated examination including but not limited to a pelvic examination**. This consent will remain on file and does not expire.

Patient Signature: ______________________________________ Date: ________________

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David I. Lubetkin, MD/Nicole Tenzel, MD
New Patient Questionnaire

Kindly fill out the enclosed personal medical history. The responses to the questions that follow will become part of your permanent office record and will remain strictly confidential. The purpose of gathering this information is to maximize the efficiency of your visit today.

Name:________________________________Age:________D.O.B.___________

Social Security Number:________________________ Marital Status:____________

What is the purpose of today's visit?

____

____

____

____

General Medical Information

Do you currently have or have had any of the following medical problems (check all that apply):

_____Asthma
_____Diabetes
_____Thyroid Condition
_____Sinusitis
_____Hay Fever/Allergies
_____Migraines
_____Seizures/Epilepsy
_____High Blood Pressure
_____Stroke

____Mitral Valve Prolapse
____Cardiac Arrhythmias
____Heart Attack
____Pneumonia
____Chron's Disease
____Ulcerative Colitis
____Kidney Stones
____Hysterectomy
____Fibroid Uterus

_____Ovarian Cysts
_____Arthritis
_____Cancer
_____Hepatitis
_____Breast Masses
_____Fibrocystic Breast Conditions
_____Liver Disease
_____History of Blood Clots

Please List Any Medical Problem Not Listed Above :

____

____

Have You Smoked in the Past NO YES If yes, number of packs per day_____ for how many years? _____

Do you Smoke Now? NO YES If yes, number of packs per day_____ for how many years? _____

Do you Drink Alcohol? NO YES If yes, How many drinks per day?___________

Review of Systems

Please Circle any of the following that pertain to you:

General:	Weight Loss	Weight Gain	fever	Fatigue
Ear Nose Throat	Sinusitis	ringing in ears	headaches	
Cardiovascular	chest pain	swelling	palpitations	Shortness of breath with exercise
Respiratory:	Coughing	Wheezing	Coughing up Blood	Shortness of breath
Gastrointestinal:	Diarrhea	Constipation	Bloody stools	abdominal pain
Genitourinary:	Blood in urine	Pain with urination	urgency	loss of urine
	Frequency of urination	Incontinence	Pain with intercourse	Change in Menstrual period
Breast:	Breast pain	Nipple discharge	Breast lump	
Neurological:	fainting	seizures	numbness	trouble walking
Psychological:	depression	anxiety		
Endocrinology:	Diabetes	Fatigue	Thyroid problems	
Hematology:	Easy Bruising	Unexpected bleeding	Swollen lymph nodes	
Menopausal symptoms:	hot flashes	Night sweats	Insomnia	

Please list all medications, prescriptions, and over the counter medications you currently take

____

____

____

Allergies to Medications: ______________________________

SURGICAL HISTORY - Please list ANY surgeries you have had and dates of surgery

____

____

____

____

GYNECOLOGIC/MENSTRUAL HISTORY

Last menstrual Period______________

At what age did you first begin to menstruate?______________

How long does your period last?______________

How many days between menstrual cycles? ______________

Are your Periods REGULAR or IRREGULAR Amount: LIGHT MODERATE HEAVY Pain: YES NO

Date of Last GYN exam ____________________

Date of Last Pap smear?____________________

Have you ever had an abnormal pap smear? ____________ If yes, please give details ________________

____

Have you ever had a bone density exam? __________ If yes, when and what were the results________________

Are you sexually active?________________ What is your current form of birth control? ________________

Have you ever been exposed to Gonorrhea, Chlamydia, Syphillis, Herpes or Genital warts (HPV)? ____________

Last mammogram? _________________________ Results? ________________________

If menopausal, are you on hormone replacement therapy? ____________ If Yes, what type? ________________

If no, were you ever on hormone replacement therapy? ____

Do you have any other gynecologic history that the doctor needs to know about? ____________________________

____

OBSTETRICAL HISTORY

Have You Ever Been Pregnant? ____________________

If yes, how many: Live Births_______ Miscarriages?________ Terminations?________ Ectopics?___________

Month	Year	Gest Age	Type of Delivery	Sex	Weight	Complications?

FAMILY HISTORY

Mother: Alive or Deceased Any significant Medical Problems? ______________________________________

Father: Alive or Deceased Any significant Medical Problems?______________________________________

Siblings: Alive or Deceased Any significant Medical Problems? ____________________________________

Any other significant family medical problems? ____

PRINT NAME________________________ **SIGNATURE** ______________________ **DATE** _________

David Lubetkin, MD

Nicole Tenzel, MD

Courtney McMillian, CNM

Nicole Ramirez, CNM

Bladder Health Questionnaire

Name ____

1. Over the past month, have you **leaked** urine (even a few drops) or wet yourself when you: Cough, Sneeze, Laugh, Walk quickly, or change position?

Not at All	1-2 Times per month	1 time a week	3-4 times a week	5-6 days a week	Every day	Your score
0	1	2	3	4	5	

2. Over the past month, have you experienced a sudden strong **urge** to urinate causing you to rush to the bathroom?

Not at All	1-2 Times per month	1 time a week	3-4 times a week	5-6 days a week	Every day	Your score
0	1	2	3	4	5	

3. How many times do you wake at night to urinate? ______________

4. Would you be interested in learning more about a treatment for leaking **WITHOUT** medicine or surgery? ________ YES ________ NO

MYRIAD myRisk Hereditary Cancer

Cancer Family History Questionnaire

Personal Information			
Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know. **The following relatives should be considered:** Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

If you can answer YES to ANY of the questions below, please text 'CRA' to 99150 to watch a short educational video prior to seeing your provider today.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, ovarian, or **pancreatic cancer** at any age	☐Y ☐N		
Colorectal or **uterine cancer** at 64 or younger	☐Y ☐N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐Y ☐N		☐M ☐P	
Two **breast cancers** (bilateral) in one relative at any age	☐Y ☐N		☐M ☐P	
Three **breast cancers** in relatives on the same side of the family at any age	☐Y ☐N		☐M ☐P	
Ovarian cancer at any age	☐Y ☐N		☐M ☐P	
Pancreatic cancer at any age	☐Y ☐N		☐M ☐P	
Male breast cancer at any age	☐Y ☐N		☐M ☐P	
Metastatic prostate cancer at any age	☐Y ☐N		☐M ☐P	
Colon cancer at 49 or younger	☐Y ☐N		☐M ☐P	
Uterine cancer at 49 or younger	☐Y ☐N		☐M ☐P	
Ashkenazi Jewish ancestry with **breast cancer** at any age	☐Y ☐N		☐M ☐P	
If you have a family history of any **other cancers**, list them here:				
Have you or anyone in your family had genetic testing for hereditary cancer?	☐Y ☐N	**Who?**	**What gene(s)?**	**What was the result?**

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)

Patient Signature ______________________________ Date __________

Healthcare Provider Signature ______________________________ Date __________

Office Use Only Patient offered hereditary cancer genetic testing? ☐Yes ☐No ☐Accepted ☐Declined

If yes, which test? ☐BRAC*Analysis*® with Myriad myRisk® ☐Multisite 3 BRAC*Analysis*® REFLEX to BRAC*Analysis*® with Myriad myRisk® ☐COLARIS®PLUS with Myriad myRisk® ☐COLARIS AP®PLUS with Myriad myRisk® ☐Single Site Testing ☐Myriad myRisk® Update ☐Other: ______________________

Follow-up appointment scheduled? ☐Yes ☐No Date of next appointment: ______________________