Date _____
Fecha

Patient Registration
Registración del Paciente

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

Patient Information - *Información del Paciente*

Social Security # _____
Numero de Seguro Social

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*

Last Name _____
Apellido

Sex _____ Date of Birth ____/____/____
Sexo *Fecha de Nacimiento*

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Estado Civil *Casada* *Soltera* *Divorciada* *Viuda*

Race/Ethnicity _____
Raza/Etnia

(Check One) ☐ Employed ☐ Retired ☐ Full-Time Student
Marque Uno *Empleada* *Retirada* *Estudiante Tiempo Completo*

☐ Other _____
Otro

Employer _____
Empleador

Work Phone (_____) _____
Telefono de Trabajo

Home Address _____
Direccion del Hogar

City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Email Address _____

Home Phone (_____) _____ Cell Phone (_____) _____
Telefono del Hogar *Telefono Cellular*

I was referred to: _____ by / *por*
Fui recomendado por

☐ Friend _____ ☐ Relative _____
Amigo *Familiar*

☐ Physician _____ ☐ Insurance _____
Médico *Seguro*

☐ Reputation of the LLC's Physicians _____
Reputación de los Médicos del LLC

☐ Existing Patient of the LLC _____
Paciente Existente de la LLC

☐ Other _____
Otro

Insurance Information - *Información del Seguro*

Please provide your insurance card to the receptionist - *Por favor entregue su tarjeta de seguro a la recepcionista*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

Insurance company _____
Compañia de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado *Relación*

Policy # _____ Group # _____ Phone ( ) _____
Numero de Poliza *Numero de Grupo* *Telefono*

Secondary Insurance Information - *Información del Seguro Secundario*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

Insurance company _____
Compañia de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado *Relación*

Policy # _____ Group # _____ Phone ( ) _____
Numero de Poliza *Numero de Grupo* *Telefono*

Emergency Contact - *En Emergencias, contactar a:*

Social Security # _____
Numero de Seguro Social

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*

Last Name _____
Apellido

Sex _____
Sexo

Home Phone (_____) _____
Telefono del Hogar

Work Phone (_____) _____
Telefono del Trabajo

Pharmacy - *Farmacia*

Pharmacy _____
Farmacia

Pharmacy Phone _____
Numero de telefono de la farmacia

Pharmacy Address _____
Direccion de la farmacia

Spouse / Guarantor / Responsible Party - *Esposo / Persona Responsable*

Social Security # _____
Numero de Seguro Social

Relationship _____
Relación

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*

Last Name _____
Apellido

Address _____
Direccion

City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Sex _____ Date of Birth ____/____/____
Sexo *Fecha de Nacimiento*

Daytime Phone (_____) _____
Teléfono durante el dia

Employer _____
Empleo

Address _____
Direccion

City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Signature Required Please See Reverse Side
Firma Requerida. Por Favor mira al Dorso

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos ciertas tarjetas de credito. Su seguro medico es un contrato entre usted y su compañia de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgements 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 judgements arising from claims of medical malpractice. This notice is pursuant to Florida law.

Hemos elegido no llevar seguro de negligencia medica o no demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (la ley 5) (g). Florida impone penas contra los medicos de los no-asegurado que no pueden satisfacer los juicios adversos que se presentan de demandas de la negligencia medica. Este aviso esta conforme a la ley de la Florida.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by the physician. I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a el medico todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compañia de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.

PATIENT'S / GUARANTOR'S SIGNATURE _____ DATE _____

Aronson Ob Gyn
www.aronsonobgyn.com

1150 N. 35th Avenue
Suite 385
Hollywood, FL 33021
Tel: 954-963-7080
Fax: 954-966-2990

2229 N. Commerce Parkway
Suite 200
Weston, FL 33326
Tel: 954-389-0000

PATIENT'S HISTORY SHEET

DO YOU HAVE AN **ALLERGY** TO ANY MEDICATION? Y / N
***IF YES, PLEASE LIST:_____
DO YOU DRINK ALCOHOLIC BEVERAGES REGULARLY? Y / N
DO YOU SMOKE? Y / N
WHAT DO YOU USE FOR CONTRACEPTION:_____

GYNECOLOGIC HISTORY:

HAVE YOU EVER HAD AN ***ABNORMAL*** PAP SMEAR? Y / N
ARE YOUR PERIODS EVER ***NOT*** REGULAR? Y / N
ARE YOUR PERIODS VERY PAINFUL? Y / N
DO YOU HAVE PELVIC PAIN OTHER THAN YOUR PERIOD? Y / N
IS YOUR PERIOD LONGER THAN 5 DAYS? Y / N
DO YOU HAVE VAGINAL BLEEDING IN BETWEEN PERIODS? Y / N
DO YOU HAVE AN ABNORMAL VAGINAL DISCHARGE? Y / N
DO YOU HAVE ANY BLEEDING WITH SEXUAL INTERCOURSE? Y / N
DO YOU HAVE ANY PAIN DURING INTERCOURSE? Y / N
DO YOU LOOSE ANY URINE WHEN COUGHING/SNEEZING? Y / N
HAVE YOU EVER HAD AN INFECTION OF YOUR TUBES / OVARIES? Y / N
HAVE YOU EVER HAD GYNECOLOGIC SURGERY? Y / N
HAVE YOU EVER BEEN DIAGNOSED WITH A SEXUALLY TRANSMITTED DISEASE? Y / N

OBSTETRIC HISTORY:

HAVE YOU EVER HAD A MISCARRIAGE? Y / N
HAVE YOU EVER HAD AN ABORTION? Y / N
HAVE YOU EVER HAD AN ECTOPIC PREGNANCY? Y / N
DO YOU HAVE ANY CHILDREN? Y / N

NAME	AGE	BIRTH WT.	VAGINAL / C-SECTION

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Ob Gyn
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MEDICAL HISTORY: CIRCLE IF ***YOU*** HAVE ANY OF THE FOLLOWING:

DIABETES HYPERTENSION THYROID DISEASE AUTO-IMMUNE DISEASE

ASTHMA ANEMIA CLOTTING PROBLEMS DEEP VENOUS THROMBOSIS

CANCER HEART DISEASE KIDNEY DISEASE NEUROLOGICAL DISEASE

ULCERS BOWEL DISEASE LIVER DISEASE ARTHRITIS MIGRAINES

PSYCHIATRIC PROBLEMS DRUG / ALCOHOL ABUSE

ANY OTHER MEDICAL CONDITION WE SHOULD KNOW?_____

SURGICAL HISTORY: IF ANY OPERATIONS, PLEASE LIST BELOW

_____

_____

DO YOU HAVE A FAMILY HISTORY OF BREAST CANCER? Y / N
DO YOU HAVE A FAMILY HISTORY OF OVARIAN CANCER? Y / N

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

HAVE YOU PREPARED AN ADVANCED DIRECTIVE? Y / N
HAVE YOU PREPARED A LIVING WILL? Y / N

PATIENT NAME: _____ **PATIENT SIGNATURE:** _____

DATE: _____

Notice of Privacy Acknowledgement

Gil Aronson, MD, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), 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 Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____