PATIENT INFORMATION RECORD

PATIENT'S NAME: _____

LOCAL MAILING ADDRESS: _____

CITY STATE ZIP CODE

2nd 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 Company _____

If your insurance is under someone else's name, please provide the following:

Subscriber's Name: _____ DOB: _____ SS#: _____

EMERGENCY CONTACT: _____ **PHONE NO.:** _____

CIRCLE LAB we are to use for your specimens: ***QUEST*** ***LABCORP***

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 deducible 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 benefits are or may become payable to me including settlements or judgements 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 disease, 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.

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 payments.

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.

_____ _____ _____

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 U.S. Hwy 441 N. Bldg. #950, The Villages, FL 32159

Patient Name: _____ **SS#:** _____ **Date:**___/___/___

Birth Date:___/___/___ Age:_____ Marital Status - M S D W Chart Number: _____

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 question, 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? _____ **If yes, when?** _____

PATIENT'S SIGNATURE: _____

DATE: _____

FOR INSURANCE PURPOSES, IS THIS YOUR:

_____ *A. ANNUAL WELL WOMEN CHECK-UP?*
INITIALS

_____ *B. DIAGNOSTIC CODED EXAM?*
INITIALS

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Patient Name: _____

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? _____

LIST MEDICATIONS THAT YOU USE REGULARLY:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

ALLERGIES:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

SURGERIES:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

PATIENT'S SIGNATURE: _____

DATE: _____