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
Diabetes		
Thyroid Disease		
Cancer of the Ovary		
Cancer of the Breast		
Cancer of the Lungs		
Cancer of the Colon		
Arthritis / Bursitis		
Back pain or Sciatica		
Anemia		
Tuberculosis		
Asthma / Sinus Allergies		
Cholesterol		
Emphysema		
Kidney Stones		
Bladder Infections		
Glaucoma		

	Self	Family
Heart Disease		
Stroke		
Varicose Veins		
Phlebitis		
Hypertension		
Slow / Irregular pulse		
Migraines		
Hepatitis or Cirrhosis		
Gallstones		
Colitis		
Diverticulitis		
Polyps in bowel		
Hemorrhoids		
Breast Disease		
Epilepsy		

SOCIAL HISTORY:

Tobacco Use: ❑ No ❑ Yes _____
Caffeine Use: ❑ No ❑ Yes _____
Domestic Violence: ❑ No ❑ Yes _____
Alcohol/Drugs Use: ❑ No ❑ Yes _____
Seat Belt Use: ❑ 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

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: _____

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
Headaches	____
Dizziness	____
Loss of consciousness	____
Mood swings	____
Fatigue	____
Muscle Weakness	____
Difficulty swallowing	____
Indigestion/Heartburn	____
Nausea or vomiting	____
Poor appetite/Weight Loss	____
Diarrhea	____
Constipation	____
Blood in bowel movement	____
Urinary problems	____
Painful urination	____
Blood in urine	____

	YES
Depression/Crying	____
Night sweats/Hot flashes	____
Water retention/Swelling feet	____
Breast mass/soreness	____
Nipple discharge or bleeding	____
Gas	____
Coughing up blood	____
Wheezing	____
Trouble walking	____
Glasses/Contacts	____
Painful intercourse	____
Shortness of breath	____
Chest pain	____
Skin rash or itching	____
Jaundice (yellow skin)	____
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: _____

NAME:_____ _____

Last First Middle Chart #

Total Pregnancies:____ Abortions:___ Twins:____Living Children:____ Date of Last Period:_____

Monthly Periods: Yes / No On Birth Control at conception: Yes / No

PAST PREGNANCIES (Last five):

Date/Month/ Year	Gestation Weeks	Length of labor	Birth Weight	Sex M/F	Type of Delivery	Anesthesia	Place of Delivery	Preterm Labor Yes/No	Comments

GENETIC SCREENING/TERATOLOGY COUNSELING Includes Patient, Baby's Father, or anyone in either family with:

	Yes	No		Yes	No
1. Patient's age 35 years or older as of estimated date of delivery			13. Huntington's Chorea		
2.Thalassemia (Italian, Greek, Mediterranean, or Asian background): MCV less than 80			14. Mental retardiation/Autism		
3. Neural tube defect (Meningomyelocele, Spina Bifida, or Anencephaly)			If Yes, was person tested for Fragile x?		
4. Congenital Heart Defect			15. Other inherited genetic or chromosomal disorder		
5. Down syndrome			16. Maternal metabolic disorder (eg, Type I diabetes, PKU)		
6. Tay-Sachs (Ashkenazi Jewish, Cajun, French canadian)			17. Patient or baby's father had a child with birth defects not listed above		
7. Canavan Disease (Ashkenazi Jewish)			18. Recurrent pregnancy loss, or a stillbirth		
8. Familial Dysautonomia (Ashkenazi Jewish)			19. Medication (including supplements, vitamins, herbs or OTC drugs) illicit/recreational drugs/alcohol since last menstrual period)		
9. Sickle Cell disease or Trait (African)			If yes, Agent(s) and strength/dosage		
10. Hemophilia or other blood disorders			20. Any other?		
11. Muscular dystrophy					
12. Cystic Fibrosis					

COMMENTS/COUNSELING:_____

_____

INFECTION HISTORY:

	Yes	No		Yes	No
1. Live with someone with TB or exposed to TB?			4. Hepatitis B, C?		
2. Patient or partner has history of genital herpes?			5. History of STD, Gonorrhea, Chlamydia, HPV, HIV, Syphilis?		
3. Rash or viral illness since last menstrual period?			If Yes, list which ones?		

COMMENTS: _____

_____

_____