My GYN Care

JOYCE R. MILLER, MD · KAREN V. SEETAL KIHEI, APRN
9700 S. Dixie Highway, Suite #1060
Miami, FL 33156

Date: _____

Reason for Visit:
Annual Well-Woman Exam (Please be advised if you have additional problems during your annual, a copay, co-insurance, and/or deductible will be charged) Yes or No

Problem Visit Yes or No
List Problem(s): _____

Patient Name: _____ DOB: _____

Email Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home: _____

Employer: _____Work: _____

Emergency Contact: _____Relationship: _____

Phone: _____

Insurance: _____ ID#:_____ Grp: _____

Subscriber Name: _____ Subscriber DOB: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Patient Signature: _____

IF YOU HAVE FILLED THIS OUT WITHIN THE LAST 12 MONTHS AND HAVE NO NEW CANCERS TO REPORT, CHECK HERE AND STOP FILLING OUT FORM: ◯

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____

Provider: Joyce Miller, MD Karen Seetal Kihei, APRN

If you answer Yes to any of the below, please LIST whether relative is maternal or paternal side using (M) for MOTHER or (P) for FATHER side and for these relatives only: Parents, Siblings, Children, Aunts/Uncles, Grandparents, Nieces/Nephews

Please circle YES or NO			Specify Relative(s) or Self	Specify Type of Cancer	Age of Diagnosis
Y	N	BREAST cancer diagnosed at age 49 or under			
Y	N	OVARIAN cancer (any age)			
Y	N	3 of the following cancers on the same side of the family: BREAST, PROSTATE, PANCREATIC (any age)			
Y	N	Male BREAST cancer (any age)			
Y	N	COLON or ENDOMETRIAL cancer in YOURSELF age 49 or under			
Y	N	3 of the following cancers on the same side of the family: COLON, ENDOMETRIAL, OVARIAN, GASTRIC, PANCREATIC, BRAIN			
Y	N	Ashkenazi Jewish Ancestry with a BREAST, PROSTATE or PANCREATIC cancer (any age)			
Y	N	Pancreatic Cancer (any age)			

FOR OFFICE USE ONLY

Patient is appropriate for GC consult: Y / N

Patient completed GC consult: Y /N

Patient accepted genetic testing: Y / N

MD Signature: _____

My GYN Care
TopLine MD Alliance
9700 South Dixie Highway, Suite 1060
Miami, FL 33156
786.453.0332 Fax 786.453.0394
Joyce R. Miller, M.D. • Karen Seetal Kihei, APRN

FLU, COVID, RSV QUESTIONNAIRE

Patient Name: _____ DOB: _____

1. Have you experienced any of the following symptoms in the last 7 days?
   - Fever Yes No
   - Cough Yes No
   - Shortness of breath or difficulty breathing Yes No
   - Sore Throat Yes No
   - Chills or body aches Yes No
   - Loss of smell or taste Yes No
   - Headache Yes No
   - Muscle aches or pain Yes No
   - Fatigue Yes No
   - Congestion or runny nose Yes No
   - Nausea, vomiting or diarrhea Yes No

2. Have you been in close contact with anyone who has been diagnosed with Flu, COVID, RSV or cold symptoms in the last 7 days? Yes No

3. Have you traveled in the last 14 days? Yes No

4. Are you currently taking antibiotics? Yes No

I hereby certify that the above statements are true and correct and understand that a false statement may disqualify me from further services.

_____ _____
Patient Signature Date

JOYCE R. MILLER, MD · KAREN V. SEETAL KIHEI, APRN

MEDICAL TEST RESULTS POLICY

We appreciate your confidence in us, and we strive to make every effort to inform you of your test results in a timely manner. Our practice is to advise you of any results (blood work, imaging studies, diagnostic procedures, etc.) within two weeks of the test being done. If you do not hear from us within two weeks of your test being performed, please contact us. In some rare instances, the test may not be processed or the results may be misdirected or misplaced. That is why it is important for you to call our office if you have not received your test results within two weeks of the test being performed. It is your responsibility to inform us if you have not received your results.

24-HOUR CANCELLATION & NO-SHOW FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, My Gyn Care reserves the right to charge a fee of $75.00 for all missed or no-show appointments or appointments not canceled with 24 hours advanced notice.

No-Show fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple no-show appointments in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand BOTH policies.

Print Name: _____ DOB: _____

Signature: _____ Date: _____

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CONSENT FOR VOICE AND TEXT MESSAGING COMMUNICATION

Name _____ DOB _____

Please select all that apply:

☐ You have my permission to leave a detailed voice message:

Telephone _____

☐ I authorize the office of My Gyn Care to discuss my medical care with the following:

Name _____ Relationship _____

Telephone _____

Name _____ Relationship _____

Telephone _____

☐ Please DO NOT release ANY medical information to anyone other than myself.

Patient Signature _____ Date _____

Witness _____