ESTABLISHED PATIENT REGISTRATION

Women's Health Partners, LLC

Diplomates of the American Board of Obstetrics & Gynecology

www.myobgynoffice.com

Reset Form | Print Form

PATIENT INFORMATION:

Today's Date: _____

Patient Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell: _____ Work: _____

E-mail: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Occupation: _____ Employer: _____

EMERGENCY CONTACT:

May we share your medical information with this contact? ☐ Yes ☐ No

Name: _____ Phone Number: _____

Relationship: _____

MEDICAL INFORMATION:

May we leave messages on your answering machines? ☐ Yes ☐ No

Primary Care MD: _____ Phone Number: _____

PREFERRED PHARMACY INFORMATION: *(used so that we can send electronic prescriptions to your pharmacy)*

Name: _____ City: _____ State: _____

Address: _____ Zip Code: _____

Claims Processing

I authorize the release of any medical information necessary to process my claims. I also authorize payment of medical benefits to physician or supplier of service as indicated on claim. In the event it is necessary to refer my account to a collection agency or an attorney, I agree to pay all collection costs, including attorney's fees and our costs.

Use of MEDICAL RECORDS and E-Mail Disclaimer

I have had an opportunity to read the HIPAA privacy notice explaining how my medical information can be used. As a healthcare entity, our messages are encrypted to maintain confidentiality according to HIPAA requirements. Please keep in mind that communications via standard e-mail over the internet are not secure. Please do not include personal identifying information, or personal medical information in any e-mail you send to us.

Risks and Responsibility

I understand that all medical care and treatment has some risks and side effects. I will make my decisions about treatment with those risks in mind and agree not to hold my physician, midwife, or any employee of Women's Health Partners liable for such side effects or adverse outcomes from treatment. I understand that all tests such as mammograms, pap smears, blood tests, and others have some degree of error and do not guarantee that I am free of disease. I also agree and understand that it is my responsibility to follow and perform tests as ordered by my healthcare provider, to be aware of the results, and to schedule and keep appointments for follow up as directed by my physician, midwife, or other employee of Women's Health Partners.

Insurance Notice

Under Florida law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY 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 judgments arising from claims of medical malpractice. This notice is pursuant to Florida Law.

I have carefully read and understand all of the above statements:

_____ _____

Signature Date