NEW 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: _____

Preferred method of communication: _____ Preferred Name (Nick Name): _____

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

May we send you our quarterly medical newsletter via email? ☐ Yes ☐ No

For Medical Purposes: Race: _____ Religion: _____ Ethnicity: _____

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

Occupation: _____

Employer: _____

REFFERED BY:

☐ Friend ☐ Relative ☐ Physician ☐ Insurance Company

☐ Reputation of our office ☐ By an existing patient ☐ Other

Name: _____

EMERGENCY CONTACTS 1:

Name: _____

Phone Number: _____

Relationship: _____

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

EMERGENCY CONTACTS 2:

Name: _____

Phone Number: _____

Relationship: _____

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

MEDICAL INFORMATION:

Primary Care Physician: _____ Phone Number: _____

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

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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IMPORTANT NOTICES

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.

Initial _____

Use of MEDICAL RECORDS
I have had an opportunity to read the HIPAA privacy notice explaining how my medical information can be used.

Initial _____

E-Mail Disclaimer
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.

Initial _____

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.

Initial _____

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 noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice.

Initial _____

This notice is pursuant to Florida Law.

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

_____ _____
Signature Date