New Patient Obstetrics & Gynecology Form

This will become part of your medical record.

Today's Date:

Name: Date of Birth: Age:

Primary Care Physician: Telephone:

Pharmacy: Pharmacy Address:

How did you hear about us?

Is there any other information you feel we should have?

Medications: Please list any medications you take, including over-the-counter medicines

MEDICINE	DOSE	HOW OFTEN	MEDICINE	DOSE	HOW OFTEN

Medical History: Please check if you or a blood-relative have had any of the following:

	MYSELF	FAMILY		MYSELF	FAMILY		MYSELF	FAMILY
Anemia	☐	☐	Mental Illness	☐	☐	Liver Disease / Hepatitis	☐	☐
High Blood Pressure	☐	☐	Depression	☐	☐	Gall Bladder Disease	☐	☐
High Cholesterol	☐	☐	Anxiety	☐	☐	Blood clots in veins/lungs	☐	☐
Heart Disease	☐	☐	Eating disorder	☐	☐	Blood Transfusion	☐	☐
Stroke	☐	☐	Migraine Headaches	☐	☐	Breast Cancer	☐	☐
Diabetes	☐	☐	Urinary Tract Infection	☐	☐	Colon Cancer	☐	☐
COPD / Emphysema	☐	☐	Lupus	☐	☐	Uterine Cancer	☐	☐
Asthma	☐	☐	Arthritis	☐	☐	Ovarian Cancer	☐	☐
Seizures	☐	☐	Back Injury	☐	☐	Other Cancer, specify:		
Thyroid problems	☐	☐	Osteoporosis	☐	☐			

Other Medical Problems (list all):

Please list any allergies to medications

Current Medical Concerns: Please circle if you have had any of the following this week:

Weight change	Yes	No	Nausea / Vomiting	Yes	No	Trouble sleeping	Yes	No
Abnormal bleeding	Yes	No	Bowel changes	Yes	No	Night sweats / Hot flashes	Yes	No
Abnormal hair growth	Yes	No	Anxiety / Panic	Yes	No	Breast problems	Yes	No
Problems with urination	Yes	No	Depression	Yes	No			

Surgical History: Please list any operations, including the year, or your age when you had it:

Personal / Social History:

Occupation Marital Status

Do / Did you use tobacco products? Yes ☐ No ☐ How much?

Do / Did you drink alcohol? Yes ☐ No ☐ How many drinks per week?

Do / Did you use illicit/street drugs? Yes ☐ No ☐ Which drugs?

Have you ever been tested for HIV? Yes ☐ No ☐ Year and result:

Have you ever been a victim of physical, verbal, emotional or sexual abuse? Yes ☐ No ☐

Contraceptive and Sexual History:

Present birth control method:

Birth control methods used in the past:

METHOD	LENGTH OF USE	REASON FOR DISCONTINUATION
1)		
2)		

Menstrual History:

First day of last menstrual period

Age at first menstrual period ____ years

Number of days from the start of one period to the start of the next ____ days

Number of days that you bleed ____ days

Describe the amount of menstrual flow (circle one) light / moderate / heavy / clots

How many tampons or pads do you use on your heaviest day?

Describe the amount of menstrual discomfort (circle one) none / mild / moderate / severe

Do you bleed in between your periods? Yes ☐ No ☐

Do you bleed after intercourse? Yes ☐ No ☐

If you stopped menstruating, at what age did you stop? ____ years

Have you had bleeding or spotting since your periods stopped? Yes ☐ No ☐

Gynecological History:

Have you been vaccinated for Human Papilloma Virus (HPV) – Gardasil Yes ☐ No ☐

Have you ever been sexually active (had intercourse)? Yes ☐ No ☐

Have you had a new sexual partner in the past three months? Yes ☐ No ☐

How many sexual partners have you had in the past 3 months?

Is/Are your partner(s) male, female, or both? Male ☐ Female ☐ Both ☐

Do you experience pain or discomfort with sexual intercourse? Yes ☐ No ☐

Would you like to discuss sexual activity or birth control today? Yes ☐ No ☐

Last Pap Smear

Last Mammogram

Last Bone Density (DEXA)

Last Colonoscopy

Have you ever been on hormone therapy (estrogen / progesterone)? Yes ☐ No ☐

Any personal history of:

- Abnormal Pap Smears Yes ☐ No ☐
- Sexually transmitted diseases Yes ☐ No ☐
  - List:
- Fibroids Yes ☐ No ☐
- Endometriosis Yes ☐ No ☐
- Infertility Yes ☐ No ☐
- Urinary incontinence Yes ☐ No ☐

Obstetrical History: Please record the number of:

Pregnancies ____ Vaginal Births ____ Ectopics ____ Abortions ____

Living Children ____ C-Sections ____ Miscarriages ____

List any complications of pregnancies

Patient Signature ____ Date ____

Provider Signature ____ Date ____

PATIENT REGISTRATION

PLEASE PRINT

PATIENT INFORMATION

LAST NAME OF PATIENT	FIRST	MI	DATE OF BIRTH	AGE
MAIDEN NAME	MARITAL STATUS		SOCIAL SECURITY NO.	
ADDRESS				APT#
CITY	STATE	ZIP CODE	E-MAIL ADDRESS	
HOME PHONE	WORK PHONE		CELL PHONE	
EMPLOYED BY OCCUPATION	language spoken		DO YOU WISH TO HAVE AN ASSISTANT PRESENT DURING YOUR EXAM? ___YES ___NO ___INDIFFERENT	

REFERRED BY: DOCTOR, PATIENT, HOSPITAL OR INSURANCE

LAST NAME	FIRST	MI	ADDRESS	TELEPHONE ( )

SPOUSE INFORMATION

LAST NAME OF SPOUSE	FIRST	MI	EMPLOYER	TELEPHONE ( )
DATE OF BIRTH	SOCIAL SECURITY NO.		OCCUPATION	

INSURANCE COMPANY INFORMATION

PRIMARY INS. CO.			PPO / HMO?
POLICY #	GROUP #		
NAME OF INSURED PARTY	RELATIONSHIP	ARE YOU INSURED THROUGH EMPLOYMENT	
SECONDARY INS. CO.			PPO / HMO?
POLICY NO.	GROUP #		
NAME OF INSURED PARTY	RELATIONSHIP		

PAYMENT OF BENEFITS

I understand the doctor does not carry malpractice insurance as stated in the sign posted in the reception area. I authorize payment of benefits, as determined by the company, directly to the physician. I understand that I may still be responsible for any amount not paid by my insurance company.

AUTHORIZATION TO RELEASE INFORMATION:
I authorize the release of any medical information necessary to process my health insurance claim form.

PATIENT OR AUTHORIZED SIGNATURE	DATE

Notice of Privacy Acknowledgement

Noel Obstetrics and Gynecology, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

FINANCIAL POLICY

Thank you for choosing Noel Obstetrics and Gynecology, LLC as your health care provider. We are committed to building a successful physician-patient relationship. The following is a statement of our Financial Policy. Our office will be happy to answer any questions or concerns you may have.

PAYMENT IS DUE AT THE TIME OF SERVICE
ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT

WE ACCEPT: CASH, CHECK, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We are in network with most major insurance carriers. However, it is the patient's responsibility to verify that we are a participating provider of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all co-payments, co-insurances and deductibles must be paid at time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

HMO/REFERRALS: It is the patient's responsibility to obtain a referral form from your primary care physician if your insurance carrier requires it for your visits. If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of services rendered.

MISSED APPOINTMENTS: Unless cancelled 24 hours in advance, there is a $25.00 fee for missed appointments. Please help us serve you better by keeping scheduled appointments.

NONCOVERED SERVICES: Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

RETURNED CHECKS: Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) along with a $50.00 NSF fee from the office.

COLLECTION POLICY: Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

FORMS: There is a flat fee of $15.00 for each set of forms the office completes on your behalf.
I HAVE READ AND FULLY UNDERSTAND the Financial Policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth.

Patient Name: _____ Date: _____
Patient/Responsible Party Signature: _____

Noel Gynecology, LLC
6333 N. Federal Highway Suite 250
Ft. Lauderdale, FL 33308
Tel: 954-642-7036 Fax: 954-642-7409

Local Pharmacy Information

1) Pharmacy Name:_____

Address:_____

Phone #:_____

Fax Line:_____

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

I understand the planned procedure and I consent to a medically indicated physical examination which may include, but may not be limited to the following:

( ) a female Gynecological Exam which may include a rectal exam and a pelvic exam

( ) An Ultrasound Exam which may include a probe placed in the vagina.

( ) A rectal exam only

( ) An Ultrasound Exam which may include a probe placed into the rectum.

( ) Other procedures as listed _____

( ) Examination of external genitalia_____

This examination will be performed by any provider from _____ LLC.

The consent will remain active until I withdraw my consent in writing.

Name of Patient

_____

Signature of Patient or Patient's Representative if under 18

Date _____

Pelvic Health Survey

Today's Date: _____

Patient's Name: _____ 1. Age: ____ 2. Sex: □Female □Male

Bladder (check one):

3. How often do you leak urine (check one box)?
   - 0 □ Never
   - 1 □ About once a week or less often
   - 2 □ Two or three times a week
   - 3 □ About once a day
   - 4 □ Several times a day
   - 5 □ All the time

4. We would like to know how much urine you think leaks. How much urine do you usually leak (whether you wear protection or not)? Check one box.
   - 0 □ None
   - 2 □ A small amount
   - 4 □ A moderate amount
   - 6 □ A large amount

5. Overall, how much does leaking urine interfere with your everyday life? Please circle a number between 0 (not at all) and 10 (a great deal).

0	1	2	3	4	5	6	7	8	9	10
Not at all										A great deal

ICIQ score: sum 3+4+5= _____

6. When does urine leak? (Please check all that apply to you.)
   - □ Never—urine does not leak
   - □ Leaks before you can get to the toilet
   - □ Leaks when you cough or sneeze
   - □ Leaks when you are asleep
   - □ Leaks when you are physically active/exercising
   - □ Leaks when you have finished urinating and are dressed
   - □ Leaks for no obvious reason
   - □ Leaks all the time

Do you wear diapers, pads, or panty liners because of leaking? □Yes □No

Are you bothered by the number of times per day you have to empty your bladder? □Yes □No

Do you wake up at night to empty your bladder? □Yes □No

If Yes, How many times? _____

Do you feel you have to rush to the toilet to avoid an accidental leak? □Yes □No

Bowel:

1) Do you accidentally leak stool? □Yes □No
2) Do you have to strain to have bowel movements? □Yes □No
3) Do you pass gas when you do not want to? □Yes □No

Gynecological:

1) Do you experience pelvic pain? □Yes □No
2) Do/did you experience pain with intercourse? □Yes □No
3) Do you have a feeling of a "ball" in your vagina? □Yes □No
4) Hysterectomy? □Yes □No
5) Vaginal Dryness? □Yes □No
6) # of Vaginal Deliveries _____
7) # of Cesarean Sections _____