ACE OBGYN LLC
STEFAN NOVAC MD

Board Certified Obstetrician Gynecologist
601 N Flamingo Rd, Ste 406, Pembroke Pines, FL, 33028
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REGISTRATION FORM

Registration Date: _____/_____/_____

Last Name: _____ First Name: _____

Date of Birth: ____/____/_____ Sex: Female ☐ Male ☐ Social Security Number # _____

Mobile Phone: (_____) _____ Home Phone: (_____) _____ Work Phone (_____) _____

Consent to Call/Text: **(check box)** Yes ☐ No ☐ Email Address: _____

☐ ☐ ☐ ☐ ☐

☐ ☐ ☐ ☐ ☐ ☐

Ethnicity: (check box): Hispanic/Latino ☐ Not Hispanic/Latino ☐ Primary Language: En_____

Family Physician (PCP) _____ Phone: _____

Employer/school Name: _____ Occupation: _____full time ☐ part time ☐

Employer/school Address: _____ City: _____ Zip: _____

Guardian (If patient is <18 years old)

Last Name: _____ First Name: _____ DOB: _____

Patient's relationship w/Guardian: _____Phone: _____

Guarantor: Last Name: _____ First Name: _____ DOB: _____

Phone Number: (_____) _____ Relationship with Patient: _____

Emergency Contact: Last Name_____ Fist Name: _____

Emergency Contact Phone: (_____) _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Information: Is this an employer plan? Y N

Insurance Carrier_____Insured'sName_____Insured's D.O.B._____

ID#_____ Group # _____ Insured's SS#_____

Street Address _____ City _____ State_____ Zip _____

Phone # _____-_____-_____ Your relationship to insured [] Self [] Spouse [] Child [] Other

Secondary Insurance Information: Is this an employer plan? Y N

Insurance Carrier_____Insured'sName_____Insured's D.O.B._____

ID#_____ Group # _____ Insured's SS#_____

Street Address _____ City _____ State_____ Zip _____

Phone # _____-_____-_____ Your relationship to insured [] Self [] Spouse [] Child [] Other

Preferred Pharmacy: _____ Phone: _____

Preferred Lab: _____ Phone: _____

MEDICAL INFORMATION:

Reason for Visit: _____

Allergies: **No** known allergies ___ Yes ___ If Yes, please List: _____

_____

Please, list all the Medications: _____

_____

Family History

If YES, please specify_____

_____

_____

Social History

Smoking status: Never Smoker _____ Former Smoker___

Current every day smoker __ Current some day smoker ___ Has smoked since ___ Tobacco-years of use _____

Occupation _____ Live alone or with others: _____

Highest Level of Education_____ Are you currently employed? Yes __ No __

Changes in family/social situation: Yes ___ No ___ Number of children _____

Exercise Level	**Diet**	**General stress level**	**Alcohol Intake**	**Caffeine Intake**
None ___	Regular ___	Low ___	None ___	None ___
Occasional ___	Vegetarian ___	Medium ___	Occasional ___	Occasional ___
Moderate ___	Gluten Free ___	High ___	Moderate ___	Moderate ___
Heavy ___	Diabetic ___		Heavy ___	Heavy ___
	Other ___			

Have you recently (within the last 12 weeks, or during a current pregnancy) traveled to or lived in a Zika-affected area: Yes ___ No ___
Illicit drugs: Yes ___ No ___

Is blood transfusion acceptable in an emergency: Yes ___ No ___ Advance directive: Yes ___ No ___

Sexual orientation: Heterosexual ___ Homosexual ___ Bisexual ___ Protected sex: Always ___ Usually ___ No ___

Performs monthly self-breast exam: Yes No

Please, List All Surgeries/Implants/Transplants and their Year

_____

_____

Gynecological History

Date of last menstrual period _____ **Periods Regular**: Yes ____ No ____ Every _____days

Number of days of flow _____ Flow: Light ____ Moderate ____ Heavy ____

Painful Periods Yes ____ No ____ **First Menstruation** (Age) _____

Date of last Pap smear: _____ Abnormal Pap Smear: Yes ___ No ___

Most recent mammogram _____ If post-menopausal, age at menopause _____

HPV Vaccine: Yes ___ No ___ Sexually active: Yes ____ No ____ Sexual problems: Yes ____ No ____

STIs/STDs (Gonorrhea- Syphilis- Chlamydia- Herpes- Human Papilloma Virus- Vaginal- HIV) Yes ____ No ____

Age at first child _____ On BCP's at conception: Yes ____ No ____

Current birth control method: _____ Desired birth control method_____

Obstetric History

Total of pregnancies ____ Full Term ____ Premature ___ Multiple births (Twins/Triplets)_____ Living Children____

Abortions induced _____ Miscarriages _____ Ectopic Pregnancies ____

Delivery Date	Weeks of Pregnancy	Hours in Labor	Birth Weight	Sex of Baby	Type of Delivery	Anesthesia	Place of Delivery	Complications

Past Medical History

None ____

Please circle:

Abuse/Domestic Violence
Acid Reflux (GERD):
Acne
Anemia
Anesthesia Complications:
Anxiety Disorder
Arthritis
Asthma
Birth Defects or Inherited
Blood Transfusion
Breast Cancer
Breast Problem
Cancer
Depression
Diabetes
Eating Disorder
Eczema
Endometriosis
Headaches
Heart Disease
Kidney disease
Epilepsy/Seizure
Fatigue/Tiredness
Decreased Libido
Osteoporosis
Blood disease
Hepatitis
High Cholesterol
Hypertension
Kidney or Bladder problems
Ovarian Cancer
Polyps
Pre-Eclampsia
Thyroid Problems
Varicosities
Infertility
Lung disease
Psychiatric Illnesses
Stroke
Fibromyalgia
GI Problem
Other: _____