River City OBGYN
Specialists in Women's Health

Current Date: _______________

Completed by: _________________

Patient Update Information

Name: ________________________________ Maiden Name: __________________________

Address: ________________________________ Date of Birth: ___________________________

________________________________ SSN: __________________________________

Race: _________________________________

Cell Phone #: ________ - ________- _________ Ethnicity: Non-Hispanic or Hispanic (Circle One)

Home Phone #: ________ - ________- _________ Email address if over age 18:

Marital Status: Single / Married / Divorced / Widowed _______________________________________

Employer: __________________________________ Pharmacy Name **and** Location:

Primary Care Physician: ________________________ _______________________________________

Emergency Contact: ________________________ Relationship to you: ______________ Phone #: ______________

Primary Insurance:

Carrier: ____________________ Plan#: ____________________ Group #:____________________

Subscriber Name: ___________________________ Relationship to insured: Self / Spouse / Child

DOB of Policy Holder: ___________ Policy Holder SSN#: _____________ Policy Holder Employer: _________________

Secondary Insurance:

Carrier: ____________________ Subscriber Name: ______________________________________

If the subscriber is not the patient, what is the relationship to the patient: Spouse / Parent / Or _______________

DOB of Policy Holder: ___________ Policy Holder SSN#: _____________ Policy Holder Employer: _________________

PLEASE INITIAL ONE BELOW:

- ____________ I **ALLOW** River City OBGYN to discuss details of my medical records/financial records with

  ____ **(Print Name, Phone # and relation to you).**

- ____________ I **DO NOT ALLOW** River City OBGYN to discuss details of my medical records/financial records with anyone else but myself.

I understand that I am responsible to River City OBGYN, for its customary fee for services rendered to me by River City OBGYN. I further understand and agree if I fail to make timely payments to River City OBGYN that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s). I hereby consent to and authorize the performance of all appropriate procedures, examinations including but not limited to a pelvic exam, and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I also consent to electronic access to my medication history.

For the services rendered by River City OBGYN, I authorize the release of my medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination of treatment. I authorize payment of medical benefits to the physician who submits the claim. I agree to hold River City OBGYN harmless from any and all costs, liability and damages of nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

Patient Signature: ____________________________________ Date: _____________________ Acct: _____________

River City OBGYN

836 Prudential Drive, Suite 1103
Jacksonville, FL 32207
Phone: (904) 398-7654 Fax: (904) 398-0118

Date:______________ (Please fill out all information to the best of your ability)

Patient's Name:______________________________________ **DOB:** ____/____/_____ **Age:**_______ **Race:**_____________

Referred by: ____ **Primary Care Physician:** ________________________________

Reason for Appt:_________________________________ **Pharmacy:**____
(Local and Mail Order)

Allergy/Reaction:____
Please list anything you are allergic to and the reaction it causes .(MEDICATION AND CONTACT ALLERGIES INCLUDED)

Medication & Dosage:____
Vaccinations: FLU VACCINE_____ TETANUS____HEPATITIS SERIES____ HPV VACCINE____ PNUEMOVAX______

Past Medical History: Have you ever had any of the following illnesses? Circle Yes or No.

Y N Have you ever had a blood transfusion? **Y N** Are you willing to have a blood transfusion to save your life?

Y N Ever had an abnormal Pap Smear? If yes, treatment____ Year:______

Y N Heart Trouble	**Y N** Osteoporosis	**Y N** Diabetes	**Y N** Gonorrhea
Y N Kidney/Bladder Problem	**Y N** Fibroids	**Y N** Blood Disorders/Clots	**Y N** Hepatitis
Y N High Blood Pressure	**Y N** Pelvic Prolapse	**Y N** Breast Discharge/Problem	**Y N** HIV
Y N Low Blood Pressure	**Y N** Depression	**Y N** Hemorrhoids	**Y N** Genital Herpes
Y N Thyroid Problem	**Y N** Endometriosis	**Y N** Anesthesia Problems	**Y N** Genital Warts
Y N Rectal Bleeding	**Y N** Seizures	**Y N** Heart Murmur/MVP	**Y N** Syphilis
Y N Stomach Trouble	**Y N** Anemia	**Y N** Antibiotic for dental work	**Y N** HPV
Y N IBS	**Y N** High Cholesterol	**Y N** Polycystic Ovarian Syndrome	**Cancer:** ________________
Y N Ulcer	**Y N** Anxiety	**Y N** Chlamydia	**Other:** ________________

Surgical History: Please list all surgeries including hospitalizations (not related to pregnancy).

Date	Procedure

Pregnancy History: ___ #OF PREGNANCIES___ #LIVE BIRTHS___#MISCARRIAGES___#ABORTIONS___#LIVING CHILDREN

Date	Delivery Type (vaginal/cesarean)	Wks	Sex	Lbs/Oz	Complications

Family History: Please list illnesses of these family members: children/mother/father/siblings/grandparents

Cancer Type	Family Member/Age
Y N Breast Cancer	
Y N Uterine Cancer	
Y N Skin Cancer	
Y N Ovarian Cancer	
Y N Colon Cancer	

Y N Heart Disease. Who?__________________________
Y N High Blood Pressure. Who:____________________
Y N High Cholesterol. Who?_______________________
Y N Blood Disorder. Who?_________________________
Y N Diabetes. Who?______________________________
Y N Thyroid Disease. Who?________________________

Other Significant Family History:____

Social History

Marital History: Single/Married/Separated/Divorced/Widowed

Use of alcohol: **Never/Daily/Moderate/Social/Rare** Use of tobacco: **Never/Current/Past ____ ppd** Use of drugs: **Never/Past/Current**

Hx of domestic violence: **Y N** Sexually active: **Y N** Birth control method:______________________________________

1st Day of Last Period:_________ Cycle Length: _________days # of days bleeding ______ Flow: light/ moderate/heavy

Last Pap:_____________ **Last Mammogram:**____________ **Last Bone Density:**____________ **Last Colonoscopy:**__________

Medication and Allergy List

Name:________________________________ DOB:________________

Name of Medication	Dosage	How Often Taken	Last Time Taken

- List other medications you are allergic to including all over the counter medications and herbal supplements. (Excluding the allergies listed on previous pages)

Allergic to:	Reaction:

Please also list allergies to environment, insects, shellfish, dyes, etc.

Martin A. Garcia, MD ▪ Erika D. Glas, DO
Tiffany A. Wells, MD ▪ Kendra K.H. Gillespie, MD
Diplomates, American College of Obstetrics and Gynecology
Jan Ely, APRN ▪ Sheri Ray, APRN ▪ Molly Turner, APRN
Claudette Mallory, APRN ▪ Michelle Buoye, APRN

Baptist Medical Pavilion ▪ 836 Prudential Drive ▪ Suite 1103 ▪ Jacksonville, FL 32207
Satellite ▪ 9889 Gate Parkway ▪ Suite 205 ▪ Jacksonville, FL 32246
Phone (904) 398-7654 ▪ Fax (904) 398-0118

Dear Patient,

In the event we prescribe narcotics, diet pills, sedatives, muscle relaxers, or other controlled substances for you, you are required by law to inform us of any other controlled substances which you have recently been prescribed or received from any other doctor. In general, this would include the prior six months period. Failure to provide this information will result in discontinuation of further controlled substances from our office and may have other legal implications for you.

Thank you for your assistance and compliance.

Your signature below acknowledges that you have read the above notice and have complied with these guidelines.

____________________________ ____________ ________________
Patient Name Printed | Date of Birth | Acct #

____________________________ ____________________
Patient Signature | Date

____________________________ ____________________
Witness | Date

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Annual Well-Woman Examination: Financial Consent

Annual Examinations are considered Preventative Care and include:

- Routine health history screening
- Breast and pelvic examinations
- Pap smear and hemocult screening, if indicated
- Ordering of screening mammogram, bone density study, colonoscopy, if indicated
- Routine Lab work, such as cholesterol, glucose, and thyroid screening
- Contraceptive counseling
- Immunizations
- Refills of annual prescriptions

Any examination, testing or consultation for a specific medical condition or concern, is considered outside the scope of Preventative Care by most insurance companies, and should be addressed at a separate office visit. For your convenience, and if time permits, our providers will attempt to address all of your concerns or problems while you are already in the office to prevent a return visit, but this will still result in an additional, separate office visit charge to your insurance company. **In accordance to your insurance policy, you may be responsible for a copayment, coinsurance or deductible for the additional office visit and any laboratory studies.**

Non-Preventative care includes: new prescriptions for acute problem, STD screening, abnormal menstrual cycles, changes in hormone therapy, infertility, and other conditions. As a general rule, additional office visit charges are assessed when significant time is spent addressing the problem; and the provider is always willing to discuss whether the problem falls outside normal preventative measures.

I understand this policy and my potential financial responsibility. I understand I am under no obligation to address my non-preventative concerns or conditions today and have the option to schedule a return office visit for further evaluation and management.

Patient Name: ______________________________ DOB: ____________________

Signature: ________________________________ Date: ____________________

Our Patient Portal is back!!!

Follow your Health with River City OBGYN

This secure, HIPAA-compliant patient portal allows you to see your lab results, vitals, health history, and upcoming appointments. You can also email your provider's office for prescription refills, questions concerning your health, or to request an appointment.

Steps to join:

- Our staff will send you an invite by email.
- Click on the link – If you previously had an account with NFOBGYN or any other provider, select that you have an EXISTING account to link these.
- User name will default to your email, but can be changed.
- Your invitation code will be the last 4 of your SSN.

Your email invitation will contain full instructions, but if you need additional help, you can email fmh@rcobgyn.com.

Follow and be engaged in your health!
Sign up below- You will receive an invitation in your email shortly. Keep this sheet and follow the instructions and be on your way to a convenient way to manage your health!

(Tear here)

Sign up to receive your patient portal invitation

Name____

Date of Birth_______________________________________

Email address_______________________________________