



### **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](mailto: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!

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(Tear here)

Sign up to receive your patient portal invitation

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Email address \_\_\_\_\_



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

\_\_\_\_\_  
(if provided, you are consenting to email correspondence)

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: \_\_\_\_\_ Plan#: \_\_\_\_\_ Group#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: Self / 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

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

Date: \_\_\_\_\_

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 \_\_\_\_\_ PNEUMOVAX \_\_\_\_\_

## 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 Heart Disease. Who? _____       |
|--------------------|-------------------|-------------------------------------|
| Y N Breast Cancer  |                   | Y N High Blood Pressure. Who? _____ |
| Y N Uterine Cancer |                   | Y N High Cholesterol. Who? _____    |
| Y N Skin Cancer    |                   | Y N Blood Disorder. Who? _____      |
| Y N Ovarian Cancer |                   | Y N Diabetes. Who? _____            |
| Y N Colon Cancer   |                   | 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: \_\_\_\_\_

1<sup>st</sup> 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 |
|--------------------|--------|-----------------|-----------------|
|                    |        |                 |                 |
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- ☐ 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: |
|--------------|-----------|
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Please also list allergies to environment, insects, shellfish, dyes, etc.

# NOTICE OF PRIVACY PRACTICES



<https://www.toplinemd.com/practice-terms-policies/>

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) provides me with certain rights regarding the privacy of my protected health information. I acknowledge that I have been provided access to the Practice’s Notice of Privacy Practices through a QR code and/or website link and have been given the opportunity to review it. I understand that the Practice may revise its Notice of Privacy Practices from time to time and that I may access the most current version by using the QR code and/or website link.

Patient Signature: \_\_\_\_\_

Patient or Legal Guardian Name (print): \_\_\_\_\_

Date: \_\_\_\_\_

### 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: \_\_\_\_\_



**Martin A. Garcia, MD**  
**Erika D. Glas, DO ▪ Tiffany A. Wells, MD**  
**Kendra K.H. Gillespie, MD**  
*Diplomates, American College of Obstetrics and Gynecology*  
**Molly Turner, APRN ▪ Michelle Buoye, APRN**  
**Ashley Maxam, DNP ▪ Karley Monberg, APRN**  
**Bailey Bunnell, PA-C**

Baptist Medical Pavilion ▪ 836 Prudential Drive ▪ Suite 1103 & 1107 ▪ Jacksonville, FL 32207  
Phone (904) 398-7654 ▪ Office Fax (904) 398-0118 ▪ Medical Fax (904) 407-3306

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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