Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name		Last Name (as it appears on insurance card or ID)	
Sex	Marital Status	Date of Birth		Social Security Number	
Patient's Address		City	State	Zip	
Home Phone		Mobile Phone		Email Address	
Referred by		Primary Care Physician		Primary Care Physician Phone	
Pharmacy	Pharmacy Phone	Pharmacy Address			

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone	
Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	
Insured's Name(as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number
Insured's Address		City	State / Zip
Insured's Social Security Number	Insured's Birthdate		

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name(as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient	
Address	City	State	Zip

Notice of HIPPA practices acknowledgement: I have read and understand the Notice of Privacy Practices.

I herby authorize the Physicians of Gentle Gynecology & Obstetrics or Staff to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim. I also authorize the Physicians of Gentle gynecology & Obstetrics or Staff to obtain medical records from other facilities or Physicians for my continued medical care. This may include but is not limited to the following reports; Pap smear, pathology, pelvic sonograms, breast imaging, Obstetrical imaging specialist reports, and laboratory results that may include H.I.V. results & diagnosis. This release is valid for 1 year from signature.

_____ _____

Signature of Patient or Authorized Guardian Date

Check-In by

Patient Responsibilities

PHI (PROTECTED HEALTH INFORMATION) DISCLOSURE)
We cannot discuss your **PHI** (protected health information) with anyone than yourself unless you authorize us to do so. Please list below the name(s) of the individual(s) you authorize our office to discuss your care with. Your **PHI** will be disclosed to the individual(s) listed below until you notify us otherwise in writing.

1. _____ 2. _____

This authorization will remain in effect for one year unless otherwise specified. I understand this authorization extends to all or any part of my medical records. I expressly consent to the release of information as designated above. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained.

If you opt for HIV screening, these results will only be given in person to the patient per HIPPA guidelines. This is the <u>"LAW"</u>.

The doctors and staff at Gentle Gynecology & Obstetrics would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible. **Please be advised that Dr. Augustino & Dr. Achille will only perform Surgery and Deliver at <u>Memorial Hospital West</u>**. If you seek care at any other hospital other than Memorial Hospital West, Dr. Augustino & Dr. Achille will be unable to care for you while you are at that facility.

RELEASE OF MEDICAL RECORDS: If you wish to release your records to yourself, another physician or someone else, **<u>written consent is required by law</u>**. We will process the request and most requests are handled within ten **(10)** business days. (Fees may apply… see release of records form for more information.)

FINANCIAL POLICY
BY INITIALING AND SIGNING BELOW YOU CONFIRM THAT YOU HAVE READ THIS POLICY AND UNDERSTAND THAT:

INSURANCE AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS
I hereby authorize Gentle Gynecology & Obstetrics to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested the medical service of Gentle Gynecology & Obstetrics on behalf of myself and/or dependents, and I understand by making this request, I become fully financially responsible for any and all charges occurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, Medicaid, private insurance and any other health/medical plan to issue payment directly to gentle gynecology & obstetrics, for medical service rendered to myself and/or my dependents regardless of my insurance benefits, if any.
I understand that not all services are covered benefits and I am responsible for any amount not paid, regardless of insurance policy. All Self Pay patients are responsible for any and all FEES for blood, cultures or sonogram testing. These fees are NOT PART of the office visit charge.

Medical malpractice: We have elected not to carry medical malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to s-458.320 (5)(g). Florida law imposes penalties against non-insured Physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida law.

<u>Patient Responsibilities</u>

- **It is your responsibility to know your insurance benefit plan, copays, co-insurance & patient responsibilities. If you are not sure of your coverage contact your insurance carrier's customer service department. We are not responsible to explain your individual insurance benefits to you.**
- **It is your responsibility to inform our office of any address or telephone number changes. Your account is to be kept current accordingly; all self-pay or insurance co-payments, co-insurance and deductibles will be collected at the time of services. Payable by: cash, check, Visa, MasterCard, and Discover.**
- **If you do not have payment(s) due at your visit your appointment may be rescheduled.**
- **A returned check will result in a $25 service charge and all future payment being required in the form of <u>CASH</u> or <u>CREDIT CARD</u>.**
- **After a second of completion of forms for Disability, FMLA, etc…. there will be a $10 charge for each additional form completion. (Allow 7 business days for completion.)**
- **If unable to keep your appointment, please notify us <u>*24 hours*</u> in advance so that we may offer that time to another patient. A pattern of repetitive "no show" or late cancellations may regretfully result in an assessment of a cancellation/no show fee of $25 for each incident and or dismissal from our practice.**
- **If your insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral faxed to our office prior to your appointment. If we do not receive your referral your appointment may be rescheduled.**
- **Doctor's collection fee for fetal Cord Blood at time of delivery is $400.00 and must be paid in full by the 28th week of pregnancy. Initials _____**

All Self-Pay patients are responsible for any and all TESTING FEES (blood, cultures, sonogram, etc.) these fees are collected at the time services are rendered. These fees are <u>NOT PART</u> of the office visit charge.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. **We are here to help you.**

I have read and fully understand the above Financial Policy and agree to meet all financial obligations.

_____ _____

Signature (Patient's Parent/Guardian, if a Minor) **Date**

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Height:

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates(Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason	Date

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details: _____

Check-In by

Name _____ Gender _____ Age _____

Date of Appointment: _____

OBGYN History

Have you ever had or do you currently have any of the following?

- ☐ Abnormal Vaginal Bleeding
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Breast Cancer
- ☐ Breast Surgery
- ☐ Cervical Cancer
- ☐ Chlamydia
- ☐ Colposcopy
- ☐ Cryosurgery
- ☐ DES Exposure
- ☐ Extreme Menstrual Pain
- ☐ Fibroids
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ Herpes
- ☐ Hot Flashes
- ☐ HPV
- ☐ Infertility
- ☐ Irregular Periods/Bleeding
- ☐ Nipple Discharge
- ☐ Ovarian Cysts
- ☐ Ovarian Cancer
- ☐ Painful Intercourse
- ☐ Pelvic Inflammatory Disease
- ☐ Uterine Cancer
- ☐ Urinary Incontinence
- ☐ Yeast Infections – Frequent

Pregnancy History

Please describe any pregnancies you have had.

# of Pregnancies _____ # of Full Term _____ # of Miscarriages _____ # of Abortions _____

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living

Were there any complications associated with any of your pregnancies?

Are you currently pregnant?

☐ Yes ☐ No

Are you trying to become pregnant?

☐ Yes ☐ No

Do you need birth control or contraceptive advice?

☐ Yes ☐ No

What method of birth control do you use?

Menstrual History

When was the first day of your last period?

How often does your period occur?

How long does your period last?

Is your period regular?

☐ Yes ☐ No

What age were you when you had your first period?

What age were you at menopause?

Health Exams & Procedures

Please check and date all immunizations you have had.

	Month & Year	Results
☐ Blood Sugar-Fasting		
☐ Breast Self Exam		
☐ Cholesterol Test		
☐ Colonoscopy		
☐ CT/CAT Scan		
☐ Dexascan (Bone Density)		
☐ EKG		
☐ Echocardiogram		
☐ Fecal Occult Blood Test		
☐ Mammogram		
☐ MRI		
☐ Pap Smear		
☐ Physical Exam		
☐ Cardiac Stress Test		
☐ Ultrasound		

Check-In by _____

Name _____ Gender _____ Age _____

Date of Appointment: _____

Review of Systems

General
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Hair Loss
- ☐ Hair Growth – Excessive
- ☐ Night Sweats
- ☐ Sleeping Problems
- ☐ Thirst - Excessive
- ☐ Weight Gain
- ☐ Weight Loss

Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ Loss of Interest
- ☐ Feeling Hopeless
- ☐ Hearing Voices
- ☐ Marital Problems
- ☐ Panic Attacks
- ☐ Trouble Concentrating
- ☐ Suicide –Thoughts/Attempts

Musculoskeletal
- ☐ Back Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Neck Pain
- ☐ Shoulder Pain

Gastrointestinal
- ☐ Appetite Gain
- ☐ Appetite Loss
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Intestinal Disorder
- ☐ Lactose Intolerance
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Lack of Bladder Control
- ☐ Frequent Urination
- ☐ Painful Urination

Respiratory
- ☐ Coughing
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

ENT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earaches
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Hearing Loss
- ☐ Nose-Bleeds
- ☐ Persistent Cough
- ☐ Persistent Runny Nose
- ☐ Recurring Sore Throat
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision Halos

Cardiovascular
- ☐ Chest Pains
- ☐ Irregular Heart Beat
- ☐ Circulation Problems
- ☐ Heart Palpitations
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Skin
- ☐ Acne
- ☐ Bruise Easily
- ☐ Changes in Moles
- ☐ Dry / Sensitive Skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores That Won't Heal

Neurological
- ☐ Coordination Problems
- ☐ Convulsions
- ☐ Difficulty Walking
- ☐ Learning Disabilities
- ☐ Light-headedness
- ☐ Memory Loss
- ☐ Numbness / Tingling
- ☐ Paralysis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Tremors

Other Symptoms

_____

_____

_____

_____

_____

Race

This information is needed for prenatal testing. Please feel free to ask your doctor any question you may have regarding information gathered.

- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Check-In by _____

Gentle Gynecology & Obstetrics

Michael F. Augustino, M.D., F.A.C.O.G.
Fabienne Achille, M.D., F.A.C.O.G.
Leonardo N. Catalano, M.D., F.A.C.O.G.

Consent for Voice and Text Messaging Communication

In an effort to relay **Normal results** faster to our patients we have implemented Electronic Medical Records. I understand that in order for Gentle Gynecology & Obstetrics to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to Gentle Gynecology & Obstetrics.

I further understand that in order for Gentle Gynecology & Obstetrics to text detailed messages containing specific medical information to my cell phone I need to give my written express permission to Gentle Gynecology & Obstetrics.

I also understand that my healthcare information at Gentle Gynecology & Obstetrics is protected and a copy of the Notice of Privacy Practices is available upon my request.

Consent for Messages:
I give my written express consent to Gentle Gynecology & Obstetrics to leave detailed messages on my voicemail/answering machine about my **NORMAL** lab, ultrasound, breast imaging, prescription information, reminders or Pap smear results. I also give my written express consent that this information may be communicated to me via Text message.

I understand that "sensitive" information as noted below will be excluded.

- **No abnormal results** will be communicated via our automated system.
- **No HIV results** are disclosed by phone, mail, email or text. HIV results are only given in person to the patient as stipulated by H.I.P.P.A. Law.

Patient Name (Please Print)

Patient Signature

Date

Cell: (This number will be used for messaging)

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time.

I understand that I must provide written notice to Gentle Gynecology & Obstetrics in order to revoke this consent.