OBGYN ASSOCIATES ST. AUGUSTINE

Patient Registration and Insurance Information

Name: _____ D.O.B. _____/_____/_____ SS# _____-_____-_____
Address: _____
City: _____ State:_____ Zip: _____
Secondary Phone: _____ Primary Phone: _____
Email Address:_____ ☐decline to report

In which language do you communicate? _____

How do you prefer to be contacted? ☐Home phone ☐Cell phone ☐Patient Portal ☐standard mail

Marital Status: ☐ married ☐ domestic partner ☐ single ☐ divorced ☐ separated ☐ widowed ☐ unknown

In case of an EMERGENCY we have permission to contact Name:_____
Number: _____

Preferred Pharmacy: _____ Preferred Imaging Facility:_____

We are required by law to ask which RACE and what ETHNICITY best describes you (you may decline to report). Please choose one in each of the following categories

RACE:
☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Pacific Islander
☐White
☐Other _____
☐Decline to report

ETHNICITY ☐Hispanic or Latina
☐Not Hispanic or Latina
☐ Other _____
☐ Decline to report

PLEASE COMPLETE ALL INSURANCE INFORMATION If you do NOT have insurance, check here _____

Insurance Co._____ Name of insured_____

Policy holder's date of birth:_____ Relationship _____

Guarantor :_____ DOB: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical or medical benefits to OBGYN ASSOCIATES for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize OBGYN ASSOCIATES to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I understand I may revoke this consent at any time by notifying OBGYN ASSOCIATES in writing. OBGYN ASSOCIATES has the right to refuse treatment should I revoke or refuse this consent.

Patient Signature _____ Date _____

Privacy Issues for Patients

I have read and understand the "Notice of Privacy Practices" which is available at the front desk. A printed copy is available upon request.

Signature: _____ Date: _____

Please list the following people that you give OB/GYN ASSOC. OF ST. AUGUSTINE permission to release your detailed medical information to. IF you choose not to release your medical information, please write NONE below.

(Please print)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

OBGYN ASSOCIATES ST. AUGUSTINE
300 Health Park Blvd, Suite 3002 • St. Augustine, Florida 32086
PHONE 904.819.1500 • FAX 904.810.1023
OBGYNSTAUGUSTINE.COM

2001

OBGYN

ASSOCIATES

ST. AUGUSTINE

Office Policies

1. The doctors, nurse midwives and nurse practitioners at OBGyn Associates have the goal of providing you the most thoughtful and innovative care possible. While our practice might seem large we keep your care personal. For gynecology care you will see one provider for all of your needs. For pregnancy we take a team approach and your visits will rotate among our providers. We have established practice protocols that allow us to all stay "on the same page" for your care while giving you our unique perspectives. We will rotate your visits through all the physicians (both male and female) or the nurse-practitioners in order to facilitate us all getting to know you.

2. If your insurance requires a referral or authorization, it is your responsibility to get it.

3. Your insurance company has contracted with a lab for any blood work, PAP smears or biopsies. You should know which lab to visit for blood work. We will make every attempt to send any specimens to the correct lab. Our office does not bill for lab work; the lab company will bill you for any labs, PAP smears or biopsies.

4. Our office has a $50.00 NO SHOW FEE for an office visit and $200.00 NO SHOW FEE for an office procedure. ANY CANCELATION RECQUIRES A 24 HOUR NOTICE.

5. Balances older than 90 days are turned over to a Collection Agency and a Collection Fee will be added to your balance.

6. FMLA paperwork Fee $25 for the initial set and $10 for any additional sets.

Signature: _____ Date: _____

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WELCOME BACK TO OUR PRACTICE!
Please help us update your information

Name:_____ DOB : _____ Date:_____

I am here for ***(please check one)*** ROUTINE GYN EXAM _____ PROBLEM VISIT _____ BOTH _____

Please list any SURGERIES or MEDICAL ISSUES that have arisen since your last visit._____
_____

Current medications (Please include birth control and herbal supplements) _____
_____

Allergies/Reaction to medications_____

GYNECOLOGIC HISTORY

Any significant change in GYN history? _____
_____

Date of last menstrual period _____/_____/_____ Are your periods regular? ☐Y ☐N How long do you bleed?_____
If menopausal, age at time of last period_____
Date of last mammogram ___/___/____ Date of last colonoscopy ___/___/____ Date of last bone density ___/___/____
Have you received the HPV vaccine? ☐Y ☐N If yes, was the three shot series completed? ☐Y ☐N
Are you currently using a birth control method? ☐Y ☐N Type: _____
Do you have any history of sexually transmitted diseases? ☐Y ☐N _____

OBSTETRIC HISTORY

How many pregnancies have you had total (including miscarriages)? _____How many deliveries? _____

FAMILY HISTORY (please list significant changes in health)

	Diseases/Complications	If deceased, at what age?
Mother		
Father		
Sister(s)		
Brother(s)		
Other		

SOCIAL HISTORY

Are you a cigarette/cigar smoker? ☐Y ☐N Cig/day_____ Years of use _____ Are you ready to quit? ☐Y ☐N

Alcohol intake: (check one) ☐never ☐occasionally ☐daily

Do you have a current or past history of drug use (including misuse of prescription medications)? ☐Y ☐N

Caffeine: ☐Y ☐N amount/day: _____

Exercise level: (check one) ☐never ☐occasionally ☐moderate ☐heavy

Diet: (check one) ☐Vegan ☐Vegetarian ☐Gluten Free ☐Diabetic ☐No Restrictions

Marital Status: ☐ married ☐ domestic partner ☐ single ☐ divorced ☐ separated ☐ widowed ☐ unknown

If you are in a relationship, how long have you been with your current partner? _____

Have you ever felt threatened or unsafe in a relationship? ☐Y ☐N ☐ Past relationship ☐ Current relationship

Occupation:_____

Is a blood transfusion acceptable in an emergency? ☐Y ☐N Do you routinely use seat belts? ☐Y ☐N

MEDICAL HISTORY (Please describe any medical conditions that apply to you)

☐Y ☐N Cancer_____
☐Y ☐N Heart Disease_____
☐Y ☐N Hypertension_____
☐Y ☐N Dermatology_____
☐Y ☐N Diabetes/Gestational Diabetes_____
☐Y ☐N Thyroid Problems_____
☐Y ☐N Abdominal Digestive Problems_____
☐Y ☐N Liver Disease _____
☐Y ☐N Blood Clots/Bleeding Disorder _____
☐Y ☐N History of Chicken Pox
☐Y ☐N Migraines_____
☐Y ☐N Seizures/Epilepsy_____
☐Y ☐N Bone Fractures as an Adult_____
☐Y ☐N Depression/Anxiety/Psychiatric Disorder
☐Y ☐N Asthma_____
☐Y ☐N Autoimmune Disorder_____
☐Y ☐N Urology_____
☐Y ☐N Weight Management_____

Other :

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ADVANCED ANNUAL NOTICE

Dear Patient,

You are scheduled for your annual pap smear, breast and pelvic examination today. Our normal fee for this service is $160 for established patients and $200 for new patients. Any lab work (pap smear, blood work) that may be associated with the exam will be billed by the laboratory directly. **If you have health insurance that we will be billing for you today and you do not have a benefit for this exam, you will be responsible for this fee.** The laboratory will bill you separately for those charges.

If you have other medical concerns not related to your annual exam that you would like to discuss with the doctor at the same time and it meets necessity to bill additionally for this service, we will do so. By signing this form, you are confirming your agreement to assume financial responsibility for payment of these charges should your insurance find them not medically necessary or non-covered.

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Patient Signature: _____ Date: _____

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Name:_____

REVIEW OF SYSTEMS

In the past 1-2months have you experienced any of the following?

Constitutional

Unexplained fever?	☐Y ☐N
Night sweats?	☐Y ☐N
Unexplained weight gain?	☐Y ☐N
Unexplained weight loss?	☐Y ☐N

Ear/Nose/Throat

Difficulty hearing?	☐Y ☐N
Frequent nose bleeds?	☐Y ☐N
Sore throat?	☐Y ☐N

Cardiovascular

Chest pain?	☐Y ☐N
Shortness of breath when lying down?	☐Y ☐N
Known heart murmur	☐Y ☐N

Respiratory

Persistent cough lasting >4weeks	☐Y ☐N
Wheezing?	☐Y ☐N
Shortness of breath?	☐Y ☐N

Gastrointestinal

Abdominal pain?	☐Y ☐N
Bloating?	☐Y ☐N
Change in appetite?	☐Y ☐N

Genitourinary

Leaking of urine (incontinence)?	☐Y ☐N
Increased frequency of urination?	☐Y ☐N
Blood in urine	☐Y ☐N

Integumentary

Abnormal mole?	☐Y ☐N
Rashes?	☐Y ☐N

Neurologic

Loss of consciousness?	☐Y ☐N
Change in headache pattern?	☐Y ☐N

Psychiatric

Felt/feeling depressed or sad?	☐Y ☐N
Sleep disturbances?	☐Y ☐N

Endocrine

Heat/cold intolerance?	☐Y ☐N
Excessive hair growth?	☐Y ☐N
Increased thirst/hunger?	☐Y ☐N