GYN WOMENS CENTRE OF LAKEWOOD RANCH, LLC
REGISTRATION FORM

(Barcode)

(PLEASE PRINT)

Patient Name(Last, First, MI)			
Birth date: / /	**Age:**	**Marital status (circle one)**	**Single / Married / Divorced / Separated / Widow**
Street Address:		**Email Address:**	
City:	**State:**	**ZIP Code:**	**SS#:**
Cell Phone:	**Home Phone:**	**Work Phone:**	
Occupation:	**Employer:**		
Reason for appointment	***(please circle)*** **Yearly Gyn Problem Consult**	**Date of last yearly exam: / /**	

INSURANCE INFORMATION

(Please give your insurance card and photo identification to the receptionist.)

Please indicate primary insurance:		
Insurance ID#:	**Group #:**	**Co-pay: $**
Subscriber's name:		**Subscriber's Birth date: / /**
Patient's relationship to subscriber: ❑ **Self** ❑ **Spouse** ❑ **Child** ❑ **Domestic Partner**		
Name of secondary insurance:	**Subscriber's name:**	
Group #:	**Policy #:**	

IN CASE OF EMERGENCY

Name of local friend or relative:		
Home phone #:	**Cell phone #:**	**Relationship:**

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Preferred Pharmacy Name	**Primary Care Physician:**
Location:	**Address:**
Phone:	**Phone:**
May we call you at home? Yes No	**May we send a yearly recall to your home? Yes No**
May we leave a message at your home? Yes No	**May we call you at work? Yes No**
May we leave a message on your cell? Yes No	**May we obtain your Medication History? Yes No**

Contact Preference: (please circle one) Home Cell Work

Health Communication Preferences: (please circle)

Health Notifications: Email Phone Pt Portal Text Announcements: Email Phone Pt Portal Text

Appointments: Email Phone Pt Portal Text Billing: Email Phone Pt Portal Text

You may release or disclose information to the following:

Name:	**Relationship:**	**Phone:**
Name:	**Relationship:**	**Phone:**

PLEASE CONTINUE TO NEXT PAGE

I acknowledge and agree to adhere to the Notice of Privacy Practices as required by federal and state guidelines. I understand I may request and review a copy of these Practices at any time from the office staff. I permit the release of my pharmacy information and the release of any information, including my medical records, that may be requested by my insurance company to process any claims or as I have indicated above. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

Patient/Guardian signature	***Date***

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I have completed this form and certify that I am the patient or duly authorized agent of the patient. I authorize the providers of Ob/Gyn Women's Centre of Lakewood Ranch, LLC to provide medical care and treatment for me.

I hereby authorize payment of benefits to be made directly to Ob/Gyn Women's Centre of Lakewood Ranch, LCC and/or any of the providers individually. I understand, as the recipient of services, regardless of insurance coverage, that I am ultimately responsible for payment within 30 days of the date of service. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

Patient/Guardian signature	***Date***
Printed Name:	***Relationship:***

Dear Patients,

Our medical providers are participating in a government program that encourages the adoption of electronic health records. This technology is supposed to lead to reduced health care costs but it will also improve the quality of your care and our ability to communicate with you, our patients. As part of this program, the government requires us to record the following demographic information about you:

• Preferred language • Race • Ethnicity •

The U.S. Centers for Disease Control and Prevention (CDC) provides the options for the race and ethnicity fields that match the data collection standards defined by the U.S. Office of Management and Budget (OMB) and the U.S. Bureau of the Census (BC). We maintain secure records and assure you that this information will remain confidential. You can help us by reviewing the list of options below and providing your race and ethnicity information during registration or check-in. If you do not wish to provide this information, you may simply decline.

Thank you for your assistance!

Please identify your Race from the following CDC-defined options:

☐ African	☐ African American	☐ Alaska Native	☐ American Indian
☐ American Indian or Alaska Native		☐ Arab	☐ Asian
☐ Asian Indian	☐ Bahamian	☐ Bangladeshi	☐ Barbadian
☐ Bhutanese	☐ Black	☐ Black or African American	☐ Burmese
☐ Cambodian	☐ Chinese	☐ Dominica Islander	☐ Dominican
☐ European	☐ Filipino	☐ Haitian	☐ Hmong
☐ Indonesian	☐ Iwo Jiman	☐ Jamaican	☐ Japanese
☐ Korean	☐ Laotian	☐ Madagascar	☐ Malaysian
☐ Maldivian/N African	☐ Melanesian	☐ Micronesian	☐ Middle Eastern
☐ Native Hawaiian or Other Pacific Islander		☐ Nepalese	☐ Okinawan
☐ Other Race	☐ Pakistani	☐ Polynesian	☐ Singaporean
☐ Sri Lankan	☐ Taiwanese	☐ Thai	☐ Tobagoan
☐ Trinidadian	☐ Vietnamese	☐ West Indian	☐ White/Caucasion

Please identify your Ethnicity from the following CDC-defined options:

☐ Central American	☐ Cuban	☐ Dominican	☐ Hispanic or Latino/Spanish
☐ Latin American	☐ Mexican	☐ Not Hispanic or Latino	☐ Puerto Rican
☐ South American	☐ Spaniard		

(Barcode)

Patient Consent to the Use, Disclosure and Request of Health Information for Treatment, Payment, or Healthcare Operations and Acknowledgement of the Opportunity to Read and/or Receive the Health Information Privacy Practices

Patient Name: _____

As part of your health care, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals who contribute to your care
- Submit your diagnosis and treatment information for payment from insurance companies or others

By signing this document, and *"only as permitted by State or Federal law"*, you are giving this practice your consent to do the following:

- To disclose, as may be necessary, your health information to other health care providers (such as, referrals to or consultation with, other health care professionals, laboratories, hospitals, etc.) for your treatment and/or health care
- To request from other health care entities (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific health care information we may need for planning your care and treatment.
- To submit your diagnosis and treatment information to insurance company(s), other agencies and/or individual(s) for payment of services
- Leave appointment reminders or information, we believe necessary for treatment or payment, with a family member or on an answering machine, the information will be the minimum necessary in our professional judgment
- Discuss your health information (only as necessary in our judgment) with family members or other persons who are or may be involved with your health care treatment or payments
- Please list by name and relationship any person with whom we may not share your health or payment information (based on professional judgment, this practice has the right not to honor your request) _____

We will make available to you our *"Notice of Patient Privacy Practices"* that provides a more complete description of health information uses and disclosures as required by the HIPAA standard. You have the following rights:

- The right to read the *"Patient Health Information Privacy Practices"* prior to signing this consent
- The right to request a copy of the *"Patient Health Information Privacy Practices"* for your own personal use

I fully understand and agree to this consent and acknowledge the above rights and disclosures.

_____	_____	_____
Signature	Print name of person signing	Date

This authorization is in effect indefinitely from the date signed above unless revoked sooner.

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes [ ] No [ ] RELATIONSHIP _____. If you are not the parent, please provide a copy of your legal authority for this patient.

gyn women's centre of Lakewood Ranch, LLC

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LABORATORY TESTING

Attention All Patients:

It has been advised by your health care provider that as a result of your appointment today, we will be sending lab work to an outside lab for interpretation. If the labs ordered are subject to your deductible, co-pay, co-insurance, and in some cases not covered by insurance you will recieve a seperate lab bill for any/or all tests that were ordered by the practitioner.

We currently send all in house specimen collections to Florida Woman Care Laboratory, LLC. If they are not contracted with your insurance, they will forward to correct Lab facility.

All outside lab orders will be submitted to the lab of your choice.
Please specify as to which lab to send orders for outside of office testing to:

- ___ Labcorp of America
- ___ Quest Diagnostics
- ___ Other
  (Please specify name of other lab)_____

If your insurance is not contracted with any of the above lab facilities, please advise the nurse PRIOR to seeing the practitioner.

It is the **patient's responsibility** to know what laboratory your insurance is contractred with, please check your provider directory for the participating laboratory on your plan. Please be advised if you choose to have your labs drawn at any other facility or doctor's office there may be a delay in our office recieving the results.

_____ _____
Print Patient Name Date of Birth

_____ _____
Patient Signature Date

This authorization is in effect indefinitely from the date signed above unless revoked sooner

www.obgynwc.com
Phone: (941) 907-3008 ◦ Fax: (941) 907-3036
8340 Lakewood Ranch Blvd. ◦ Suite 240 ◦ Lakewood Ranch, FL 34202

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Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

This authorization is in effect indefinitely from the date signed below unless revoked sooner.

Parent, Patient's Signature or Authorized Representative | Date | Time

Relationship to Patient | Interpreter, if utilized

Witness Signature

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ACKNOWLEDGMENT OF POLICIES

Name of Patient: _____ Patient's DOB: _____

Parent/Guardian: _____

PLEASE READ AND SIGN

Labs

You have been advised by the health care provider that as a result of your appointment today, they will need to send lab work to an outside lab for interpretation, (ex: pap smear, biopsy, etc), If the labs ordered are not covered by your insurance, **you will receive a separate bill for any/or all tests that were ordered by the provider.** This bill will come to you from the lab directly.

Pharmacy

It is your responsibility to provide our office with your preferred pharmacy name and phone number. Please make sure that you provided the correct information to the front desk and/or nurse.

Authorizations/referrals:

If your insurance requires and authorization or referral from your Primary Care Physician, it is your responsibility to make sure we have this prior to being seen in our office.

Returned Check Charge:

If we receive a returned check from your bank due to non-sufficient funds, closed account, etc. you will be charged an administrative fee of $35.00. Future services will require payment by cash, money order, or credit/debit card.

Co-Pays/co-insurance/deductibles:

Co-pays, co-insurance/deductibles are due at the time of service. Patients will be asked to reschedule their appointment if the appropriate funds are not collected.

Completion of Forms:

There is a $25.00 charge per form for all FMLA, short term and long term disability forms. Payment will be collected at the time the paperwork is received in our office. Paperwork will be completed as quickly as possible (up to 2 weeks). Our office will contact you when it is completed.

Patient Responsibilities

As a patient, it is **your** responsibility to know if you plan is contracted and in network with our group and to understand your insurance plan benefits. Policies and coverage may vary from year to year.

I have read, understand and acknowledge I have received the financial policy.

Signature of Patient or Guardian _____ **Date:** _____

This authorization is in effect indefinitely from the date signed above unless revoked sooner.

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GYN Women's Centre of Lakewood Ranch, LLC
HEALTH QUESTIONNAIRE
(Please Print)

(Barcode)

Today's date:			
Patient's last name:		**First name:**	**MI:**
Age:	**Date of Birth:**	**Primary Physician:**	
Reason for your visit today:			
Allergies (*Medications, Latex, Iodine...*):	**Reaction** (*Rash, Hives, Anaphylaxis...*):	**Severity** (*Severe, Mild...*):	

Current Prescribed Medications:			**Name:**	**Strength:**	**Directions:**
Name:	**Strength:**	**Directions:**			

GYNECOLOGICAL HISTORY

Date of Last Menstrual Period?	**How often do your menstrual periods occur?**
Is the Flow: Light Moderate Heavy Cramping Y/N	**How many days do your menstrual periods last?**
If postmenopausal age at Menopause:	**At what Age did you begin menstruation?**
Current Birth Control method:	**HPV Vaccination Series Completed? Yes No If Yes when?**
Do you have any history of Sexually Transmitted Diseases? Yes No If yes, which:	
Date of Last Pap and result:	**Date of Last Mammogram and result:**
History of Abnormal Pap Smear:	**History of Abnormal Mammograms:**
Date of Last Colonoscopy:	**History of Breast Problems? Yes No**
Are you sexually active? Yes No	**Sexual Orientation: Hetero / Homo/ Bi sexual**
Total Life time Partners? NONE Less than 5 More than 5	**Date of Last Bone Density (Dexa):**
Age at first sexual experience:	**History of Endometriosis /Fibroids /Infertility/ Ovarian Problems?**

OBSTETRICAL HISTORY

How many times have you been pregnant?	**How many children do you have?**
Any miscarriages? Yes No How Many?	**Any abortions? Yes No How Many?**
Any Ectopic Pregnancies? Yes No How Many?	**Any Premature Deliveries? Yes No How Many?**

Pregnancy History:

DOB:	#of Fetus	Full or PreTerm/ Gestational Weeks	Length of Labor (hours)	Birth Weight lbs/oz	Sex	Delivery Type	Anesthesia	Complications
/ /		/		/				
/ /		/		/				
/ /		/		/				
/ /		/		/				
/ /		/		/				
/ /		/		/				

PAST MEDICAL HISTORY (please circle)		
Cancer-BRCA Tested	GI-Colon Polyps	Ortho-Other
Cancer-Breast	GI-Crohn's/Ulcerative Colitis	Psych-ADD
Cancer-Cervical	GI-Gallbladder Disease	Psych-Anxiety Disorder
Cancer-Colon	GI-Hemorrhoids	Psych-Bipolar Disease
Cancer-Endometrial/Uterine	GI-Irritable Bowel Syndrome	Psych-Depression
Cancer-Lung	GI-Liver Disease/Hepatitis	Psych-Eating Disorder
Cancer-Other	GI-Other	Psych-Other
Cancer-Ovary	GI-Reflux/Stomach Ulcers	Psych-PMS/PMDD
Cancer-Skin/Melanoma	GI-Vitamin Deficiency	Pulmonary-Asthma
Cancer-Vaginal	Hematology-Anemia	Pulmonary-COPD/Emphysema
Cancer-Vulvar	Hematology-Bleeding Disorder	Pulmonary-Other
Cardiac-Heart Arrhythmia	Hematology-Blood Clotting Disorder/Factor 5 Leiden	Pulmonary-Seasonal Allergies
Cardiac-Heart Disease	Hematology-Blood Transfusion	Pulmonary-Sleep Apnea
Cardiac-High Blood Pressure	Hematology-DVT/Pulmonary Embolism	Rheumatology-Arthritis
Cardiac-High Cholesterol	Hematology-Other	Rheumatology-Autoimmune Disease
Cardiac-Other	ID-Shingles	Rheumatology-Fibromyalgia/Chronic Pain
Dermatology-Acne	ID-HIV	Rheumatology-Other
Dermatology-Eczema/Psoriasis	ID-MRSA	Rheumatology-Restless Leg Syndrome
Dermatology-Other	ID-Other	Urology-Frequent UTI
ENT-Hearing Loss	ID-Rheumatic Fever	Urology-Hematuria (blood in urine)
ENT-Other	ID-Tuberculosis/Positive PPD	Urology-Interstitial Cystitis
Endocrinology-Diabetes/History of Gestational Diabetes	ID-Usual Childhood diseases-Chicken Pox	Urology-Kidney Disease
Endocrinology-Elevated Prolactin	Neurology-Headaches/Migraines	Urology-Kidney Infection
Endocrinology-Osteopenia	Neurology-Memory Loss/Dementia	Urology- Other
Endocrinology-Osteoporosis	Neurology-Neuropathy	Urology-Urinary Incontinence
Endocrinology-Other	Neurology-Other	Urology-Kidney Stones
Endocrinology-Thyroid Problems Hypo/Hyper/Other	Neurology-Seizures/Epilepsy	Wt Management-Obesity
Eyes-Cataracts	Neurology-Stroke/TIA	Wt Management-Other
Eyes-Glaucoma	Ortho-Chronic Back Pain	
Eyes-Other	Ortho-Degenerative Joint Disease	
Eyes-Vision Loss/Macular Degeneration	Ortho-Fractures	

GENERAL MEDICAL HISTORY/REVIEW OF SYSTEMS		
Occupation:	Highest Level of Education:	
Exercise Level: Low Med High	Diet: Regular / Vegetarian / Other:	Wear seatbelt Routinely? Yes / No
Marital Status: Single / Mar / Divorced / Sep / Widowed		
Smoking Status: Never / Former / Current / Occasional	How much per day?	How many years?
Alcohol Intake: None / Occasional / Moderate / Heavy	If applicable: Use Pre-Pregnancy? Yes / No	
Caffeine Intake: None / Occasional / Moderate / Heavy	If applicable: Use Pre-Pregnancy? Yes / No	
Illegal Substance: None / Occasional / Moderate / Heavy	If applicable: Use Pre-Pregnancy? Yes / No	
Is a blood transfusion acceptable in emergency? Yes / No	Any history of Domestic Violence? Yes / No	

FAMILY HISTORY

	Age	If Living-please list serious medical conditions & onset Age	Age at Death	Cause of Death
Father				
Mother				
Brother				
Sister				
Maternal Grandmother				
Maternal Grandfather				
Maternal Aunt				
Maternal Uncle				
Paternal Grandmother				
Paternal Grandfather				
Paternal Aunt				
Paternal Uncle				

SURGICAL HISTORY

Date:	Type:	Physician:
Date:	Type:	Physician:
Date:	Type:	Physician:
Date:	Type:	Physician:
Date:	Type:	Physician:
Date:	Type:	Physician:
Date:	Type:	Physician:

VACCINE HISTORY

Date:	Type:
Date:	Type:
Date:	Type:
Date:	Type:

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect or incomplete information can be dangerous to my health. I acknowledge and agree it is my responsibility to inform Ob/Gyn Women's Centre of Lakewood Ranch, LLC of any changes in my medical status prior to receiving medical treatment. I also authorize the healthcare staff to perform and order any necessary services I may need.

Patient/Guardian signature	*Date*

Consent for Pelvic Examination

According to The American College of Obstetricians and Gynecologists, the pelvic examination is part of the evaluation of women presenting with many common conditions, including pelvic pain, abnormal bleeding, vaginal discharge, and sexual problems. Pelvic exams—both in the office and while under anesthesia— are also an important part of evaluation for gynecologic procedures to ensure safe completion of the planned procedure. Often, a pelvic examination is performed for women without symptoms while looking for gynecologic cancer, infection, and pelvic inflammatory disease.

A pelvic examination is an assessment of the external genitalia; internal speculum examination of the vagina and cervix; bimanual palpation of the adnexa, uterus, and bladder; and sometimes rectovaginal examination.

Reasons for a pelvic exam can include (but are not limited to) health screening, abnormal bleeding, pelvic pain, sexual problems, vaginal bulge, urinary issues, or inability to insert a tampon. Other indications include patients undergoing a pelvic procedure (e.g., endometrial biopsy or intrauterine device placement). Also, pelvic examination is indicated in women with current or a history of abnormal pap results, gynecologic cancers, or toxic exposures.

The potential benefits of a pelvic examination include the detection of vulvar, vaginal, cervical, uterine and ovarian cancers and precancers, yeast and bacterial vaginosis, trichomoniasis, and genital herpes, early detection of treatable gynecologic conditions before symptoms begin occurring (e.g. vulvar or vaginal cancer), as well as incidental findings such as dermatologic changes and foreign bodies. Additionally, screening pelvic examinations in the context of a well woman visit may allow gynecologists to explain a patient's anatomy, reassure her of normalcy, and answer your specific questions.

The potential risks of a pelvic exam may include (but are not limited to) fear, anxiety, embarrassment (reports ranged from 10% to 80% of women) or pain and discomfort (from 11% to 60%).

There are few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluative information and carry their own set of potential risks. If you have concerns, you should discuss with your healthcare provider.

I _____ understand that this Patient Consent Form is required by law. I understand that I need to sign this form to show that I am making an informed decision to have pelvic examinations and I have read and understand the above and that I am providing both written and verbal consent and that in obstetrical situations multiple pelvic exams may be necessary during the course of care and I hereby provide consent.

I understand that my provider may be involved in educating tomorrow's medical professionals and that familiarizing students with the female anatomy and instilling a physician workforce with confidence in pelvic examination skills is essential. I also consent to pelvic examination by the medical professional student under the supervision of my medical provider and I may verbally withdraw such consent at any time.

The provider or their delegate has explained to me the nature, purpose, and possible consequences of each procedure as well as risks involved, possible complications, and possible alternative methods of treatment. I also know that the information given to me does not list every possible risk and that other, less likely problems could occur. I was not given any guarantee from anyone about the final results of this procedure.

_____ ____/____/_____

Signature Date

gyn women's centre of Lakewood Ranch, LLC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY REQUEST AND AUTHORIZE: OB/GYN WOMEN'S CENTRE OF LAKEWOOD RANCH, LLC

☐ JORGE E. ALVAREZ, MD ☐ JENNIFER R. MCCULLEN, MD ☐ EDGARDO J. APONTE, MD
☐ Danielle Pizzo, APRN, FNP-C

TO: ☐ OBTAIN FROM DOCTOR'S NAME _____

☐ SEND TO DOCTOR'S ADDRESS/FAX _____

THE FOLLOWING MEDICAL INFORMATION

☐ ALL MEDICAL RECORDS ☐ SPECIFIC INFORMATION

☐ SPECIFIC INFORMATION
I WISH TO HAVE RELEASED: _____

FOR THE MEDICAL RECORDS OF: (PLEASE PRINT)

PATIENT'S
NAME _____ D.O.B. _____ SSN _____

I understand that I may revoke this consent at any time, by submitting such a request in writing, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

SIGNATURE _____ DATE _____

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.

☐ I DO consent to have this information disclosed ☐ I DO NOT consent to this information being disclosed.

SIGNATURE _____ DATE _____

This medical record may contain information concerning HIV testing and / or AIDS diagnosis. Separate consent must be given before this information can be disclosed.

☐ I DO consent to have this information disclosed ☐ I DO NOT consent to this information being disclosed.

SIGNATURE _____ DATE _____

REASON FOR REQUESTING RECORDS: _____

SIGNATURE _____ DATE _____

If records are less than 10 pages, please fax. If records exceed 10 pages, please mail.

OB/GYN WOMEN'S CENTRE OF LAKEWOOD RANCH, LLC RESERVES THE RIGHT TO CHARGE A FEE FOR THE SERVICE OF COPYING MEDICAL RECORDS. THERE WILL BE A MINIMUM FEE OF $15.00 FOR THIS SERVICE. OUR OFFICE DOES REQUIRE A MINIMUM OF 72 HOURS PRIOR NOTIFICATION FOR COPYING OF MEDICAL RECORDS.

PHONE #: (941) 907-3008 **FAX #: (941) 907-3036**

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