NEW PATIENT REGISTRATION FORM

Acct#:__________________

Today's Date_________________
Last 4 Digits of Social Security #________________ **Email**____

Last Name___________________________________ **First** Name_________________________________MI____

Nickname/Maiden Name__________________________________

Address____
Apt/Unit #__________

City____ State____________ Zip________________

Home Phone (_____)_____________ Work Phone (_____)____________ **Cell Phone** (_____)______________

Age_____ Date of Birth_____/_____/_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Gender: ☐ F ☐ M

Race: **(Optional)** ☐ Black ☐ White ☐ Asian ☐ Hispanic ☐ Other

Employer ______________________________________

Occupation______________________________________

How did you hear about us? : ☐ Personal Reference___________________________
☐ Physician_________________________ ☐ Internet ☐ Yellow Pages ☐ Newspaper/ Magazine/ Television
☐ Other __________________________

EMERGENCY CONTACT

Name____ Relationship__________________________________

Home Phone (_____)_____________ Work Phone (_____)_____________Cell Phone (_____)________________

INSURANCE INFORMATION

Primary Insurance Company Name____
Phone # (_____)_______________________
Insured Name (if other than self) ____
Relationship__________________________

Last 4 Digits of Social Security #_______________________________
Date of Birth_____/_____/_____

Policy/Member #____
Group #__________________________________

Employer Providing Insurance____

Secondary Insurance Company Name____
Phone # (_____)_______________

Insured Name (if other than self) ____ Relationship__________________

Form Rev. 10/1/17

Last 4 Digits of Social Security # ______________________
Date of Birth_____/_____/_____

Policy/Member #____
Group #____________________________

Employer Providing Insurance____

PRIMARY CARE PHYSICIAN

Name______________________________ Phone # ____________________________

PHARMACY

Name______________________________ Phone #____________________________

PHI DISCLOSURE

We cannot discuss your protected health information (PHI) with anyone other 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 unless you notify us otherwise in writing.

______________________________ ______________________________

______________________________ ______________________________

Please specify anything that you do NOT want to be released:

____

I understand this authorization extends to all or any part of my medical record, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol /drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. 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, except to the extent that action has already been taken on the authorization. I understand that my PHI used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my PHI may no longer be protected by law. **Parents/Guardians: Minor patients may consent to certain services and limit access to certain protected health information such as care related to pregnancy, birth control, STIs/STDs, and HIV under state law.**

INSURANCE AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize Women's Care Florida 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 medical services from Women's Care Florida on behalf of myself and/or my dependents, and I understand by making this request, I become fully financially responsible for any and all charges incurred 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, Medigap, private insurance and any other health/medical plan to issue payment directly to Women's Care Florida, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance, regardless of insurance coverage.

CONSENT TO TREAT

The purpose of medical care is to facilitate the treatment of disease, injury and disability. Medical services are provided through examination, testing and use of procedures to the aid of diagnosis or treatment of a medical condition or conditions. I request and authorize Women's Care Florida to provide me with medical services as described above. I agree to cooperate fully and to participate in all medical procedures and to comply with the plan of medical care/services that is established.

I acknowledge I have received a copy of the Women's Care Florida "Notice of Privacy Practices". I have read and understand all of the above and agree to comply.

Date______________________**Signature**____

Responsible Party Signature (required if patient is under 18):

____

To be completed by office staff, if applicable:

On this date the patient presented for treatment and was provided with a copy of the practice's Notice of Privacy Practices. Although a good faith effort was made to obtain a written acknowledgement of receipt of Notice of Privacy Practices, one was not obtained because:

____ Patient refused to sign.

____ Patient was unable to sign or initial because: ____

____

Responsible Party – Adult present signing consent to treat

Relationship to Patient____

Last Name____

First Name____________________________________ MI______

Last 4 Digits of Social Security # _________________________ Date of Birth____/____/____.

Gender ☐F ☐M

Address____

Apt/Unit #__________________

City____ State______________ Zip_________________

Home Phone (______)________________ Work Phone (______)_________

Patient Name: ______________________________________ WOMEN'S CARE FLORIDA D/B/A NORTH FLORIDA OB-GYN ("Women's Physicians of Jacksonville-WPJ") FINANCIAL AGREEMENT

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have had the opportunity to review a copy of **Women's Care Florida HIPAA Notice of Privacy Notice** dated **December 1, 2018** ("Notice"). I understand that I am responsible to read this Notice and notify Women's Care Florida d/b/a North Florida Ob-Gyn (**WPJ**), in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. The Practice has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times and on our website at www.nfobgyn.com. The Practice will provide me with a copy of the most recent Notice upon request.

Patient Signature: ______________________________ **Date of Birth:**____________________

Parent, Guardian or Legal Representative Signature:______________________________

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at the Practice. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services. For surgery and pregnancy, the Practice will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, procedure or pregnancy, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. Any patient credits will be applied to my other outstanding patient balances prior to any refund issued. I further understand that such payment is not contingent on any insurance, settlement or judgment payment.

The Practice may authorize its management services company – Physician Business Services, LLC – to file a claim for payment and accept assignment with my insurance company as required by contractual agreement. If the insurance company fails to pay in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed. Should the account be referred to a collection agency or attorney for collection, the undersigned agrees to pay the collection agency's fee (based on a percentage of your account balance, the current percentage is 35%) and all costs of collection, including a reasonable attorney's fee.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is **my responsibility** to provide the Practice with a copy of my **current insurance** card and, if required by my insurance, **to obtain a referral** from my Primary Care Physician. The Practice is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay (or Self-Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify the Practice immediately upon any change to my insurance**.

INSURANCE WAIVER , NON-COVERED SERVICES WAIVER and OUTSIDE LAB SERVICES

I understand that if I do not have a copy of a current insurance card and/or valid referral, the Practice is not obligated to see me. But if I still wish to be seen, I can be seen as a "Private Pay"/"Self-Pay" patient. I agree that neither the Practice nor I, will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan "Non-Covered Services." I understand that I must pay for Non-Covered Services. If feasible, a waiver will be completed for each Private Pay visit or Non-Covered Service. I understand services sent to an outside laboratory are billed to my insurance or to me by the lab and I will receive a separate invoice from the laboratory.

ANNUAL EXAMS (Including Medicare Annual Visits)

Annual "well-women" exams are preventive visits and are not paid for by all insurance carriers. Medicare only pays for a portion of this exam (Pap, Pelvic and Breast Exam) once every two (2) years. I understand that I am responsible for payment, if the exam or portion of the exam is not covered by my insurance.

Annual exams do not typically include problems which I may be having, as problem visits may require longer time. If I am experiencing problems, the office may be required to reschedule another visit to address these concerns.

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures 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.

ADDITIONAL INFORMATION

Payment may be made to Women's Care Florida, LLC (**WPJ**) in the form of: Cash, Check, Debit and Credit Cards. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to me by the Practice. Patient credits are applied to other outstanding patient balances prior to any refunds that may be issued, including balances owed to other offices (units) of the Practice.

I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility, including deductible, at the time of service, for telephone management services, for educational materials, for payment agreements which extend beyond 12 months, and for other administrative expenses not covered by my insurance plan.

ASSIGNMENT OF BENEFITS

For the services rendered by the Practice, I authorize the release of any 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 or treatment. I also request payment of government benefits either to myself or to the party who accepts assignment (**WPJ**). I agree to hold the Practice, its subsidiaries and affiliates, their shareholders, officers, directors, employees and agents, harmless from any and all costs, liability and damages of and nature whatsoever, including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient's Printed name ______________________ **Patient's Date of Birth:** ______________________

Patient's Signature: ______________________ **Date signed:** ______________________

Parent, Guardian or Legal Representative Signature: ______________________

Employee's signature who reviewed intake of form: ______________________

Please answer the following questions and mail or fax back to 821-3113 prior to your appointment.
COMPLETE FORM IN BLACK INK

Name____________________ Today's Date__________ Age_______

Marital Status (Circle One) Single Married Divorced Separated Widowed

Occupation__________________ Education__________________

Religion______________ Race or nationality__________________

Referring Physician if applicable______________________________

Reason for visit______________________________

Date of last pap smear__________ Last mammogram______________ Last Cholesterol screening______________

Date of last bone density study__________ Last colonoscopy______________

Social History: Tobacco use now________ Type and daily amount______________________

How long have you used tobacco______________________Smoked in the past______ If stopped, when________

Alcoholic beverages Type & how frequently consumed______________________________

Do you exercise______ How often__________What type______________________________

Any history of drug abuse: when used and type______________________________

Has anyone you live with or care about harmed or threatened to harm you?______________________

Do you wear seatbelts________ In the event of a life threatening emergency; are you willing to accept a blood transfusion? Yes____ No____

Gynecologic History: 1st day of your last period__________ Age at first period_______ # of days your periods last______

# of days between periods (1st day of period to 1st day of next period)______ Menstrual flow: ____light ____medium____ heavy______

Do you bleed between periods__________ Do you pass clots________ If you stopped having periods, at what age__________

Have you ever had an abnormal Pap Smear_______ If yes, when__________What were the findings of the Pap Smear__________

List any procedures or treatments for this abnormal result______________________________

Are you currently sexually active? ___Yes ___No If Yes, are you sexually active with (circle all that apply) Men Women Both

Current Method of birth control: (circle all that apply) Pill Patch IUD (Mirena or Paragard) Vaginal Ring Diaphragm Condoms

Rhythm Tubal Ligation Vasectomy Creams Foam None Other______________________________

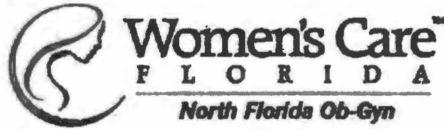
Do you have a history of the following (If yes, list approximate date of diagnosis) Cervical cancer________ Uterine cancer__________

Ovarian cancer_______ Breast cancer_______ Uterine fibroids_______ Polycystic ovary syndrome_______ Infertility__________

Chlamydia/gonorrhea/syphilis_________ HIV/AIDS_________ Tubal or pelvic infection__________ Genital herpes__________

Human papilloma virus_______ Gardasil/Cervarix HPV vaccination_______ Endometriosis_______ Abnormal vaginal bleeding______

Pelvic pain_______ Pituitary tumor_________ Blood clots in legs_________ Other______________________________



Pregnancy History: Number of pregnancies _____ Full Term _____ Preterm _____ Stillborns _____

Tubal Pregnancies _____ Elective Abortions_____ Miscarriages_____ # of Multiple Births (Twins, Triplets) _____

Date of Birth	Weeks at Delivery	Weight	Sex	C-section/Vaginal	Anesthesia	Complications	Location

Past Medical History – Have you had any of the following, If yes, please list approx. year of diagnosis

Diabetes__________ Heart disease_________ High blood pressure_________ Hypothyroid________ Hyperthyroid___________

Gallbladder disease/gallstones________ Liver disease/hepatitis________ Kidney stones________ Kidney disease ____________

Bladder infections _____ Anxiety/panic attacks ______ Depression _______ German measles ________ Chicken pox _________

Multiple sclerosis________ Osteoporosis_________ Broken bones _______ Arthritis_________ Sickle cell trait ___________

Tuberculosis_______ Asthma_______ Cancer_________ Any other serious illness__________________________________

Family History Please check illnesses that have occurred in your immediate blood relatives and list which relatives.

M = Mother F= Father S= sister B= brother A= Aunt U= uncle MGM= Maternal Grandmother
MGF= Maternal Grandfather PGM= Paternal Grandmother PGF= Paternal Grandfather

Colon cancer __________ Breast cancer __________ Ovarian cancer __________ Uterine cancer__________

Diabetes _________ Heart disease_________ High blood pressure __________ Stroke ________ Thyroid problems __________

Tuberculosis __________ Osteoporosis________ Kidney disease _________ Abnormal bleeding _________

Alzheimer's _________ Depression/nervous disorder ___________ Other _______________________________________

Women's Care™
FLORIDA
North Florida Ob-Gyn

Hospitalizations:

Date Reason

____

____

____

Surgeries:

Date Type of surgery Name of Hospital Name of Surgeon

____

____

____

____

____

Allergies:

Medication name What type of reaction does this medication cause

____

____

____

____

Current Medications: Please list both prescription and over the counter medications

Name	Dosage	# Times/Day	Name	Dosage	# Times/Day

Family Planning:

Are you finished having children? Yes______ No______ Maybe______

Would you be interested in permanent birth control with no cutting, no scarring, & no hormones?

Yes______ No______ Maybe______

Urinary Incontinence:

Do you leak urine when you cough, sneeze, laugh, or during physical activities?

Frequently_______ Sometimes_______ Never______

Do you usually have a strong sense of urgency to urinate?

Frequently_______ Sometimes_______ Never______

Does the loss of urine or overactive bladder affect your quality of life?

Frequently_______ Sometimes_______ Never______

Medicare Screening: For patients with Medicare.

At what age did you first become sexually active: ___Before 16 years old___After 16 years old.

Have you had more than 5 sexual partners in your lifetime? ____ Yes ___ No

Any personal history of sexually transmitted infections/diseases? ____ Yes ___ No

Pap Smear within the last 7 years? ____Yes ____ No

Daily exposure to tabacco (smoke)? ___ Yes ___ No

Patient Name: ________________________________ Date of Birth: __________ ID# ____________________

Revised 1/2020

Hereditary Cancer Risk Assessment

This brief questionnaire will help determine if you are at risk for a hereditary cancer predisposition. Depending on your personal and family history, genetic counseling and/or genetic testing may be recommended.

Please report cancer history for:
Yourself, parents, siblings, aunts/uncles, grandparents, grandchildren, nieces/nephews, great-grandparents and first-cousins

Do you have a personal or family history of:		**Which Relative(s)?**	**Maternal (M) or Paternal (P) side of the family?**	**Age at diagnosis?**
Breast cancer before 45	□ Yes □ No		□ M □ P	
Two **breast cancers** on the same side of the family with one diagnosed before age 50	□ Yes □ No		□ M □ P	
Three **breast cancers** on the same side of the family at any age	□ Yes □ No		□ M □ P	
Ovarian cancer at any age	□ Yes □ No		□ M □ P	
Pancreatic cancer at any age	□ Yes □ No		□ M □ P	
Male breast cancer at any age	□ Yes □ No		□ M □ P	
Metastatic prostate cancer at any age (died from the prostate cancer)	□ Yes □ No		□ M □ P	
Colon cancer under age 50	□ Yes □ No		□ M □ P	
Uterine/endometrial cancer under age 50	□ Yes □ No		□ M □ P	

If patient answers yes to any of the above questions, genetic counseling is not required prior to testing. If patient answers yes to any of the questions below, please consider referring for genetic counseling.

Question	
Do you have Ashkenazi Jewish ancestry?	□ Yes □ No
Has anyone in your family had a positive genetic testing for hereditary cancer? (ex: mom tested positive for BRCA1) *****Please provide a copy of the family member's report if possible**	□ Yes □ No
Has anyone in your family had: o Triple negative (hormone negative) breast cancer o Kidney cancer o Medullary thyroid cancer o Brain cancer o Three or more melanoma skin cancers o Tumors on the adrenal gland o 10 or more colon polyps over lifetime	□ Yes □ No

Please share any additional details you would like to share below:

FOR OFFICE USE ONLY:

Patient offered hereditary cancer genetic testing?: □ Y □ N   Patient □ Accepts testing □ Refuses testing

Patient referred to genetic counseling?: □ Y □ N   Patient □ Accepts referral □ Refuses referral

*** CIGNA PATIENTS MUST HAVE PRE-TEST COUNSELING WITH A CERTIFIED GENETIC COUNSELOR

*** Medicare, Medicaid, and Aetna have specific guidelines other than NCCN- consider genetic counseling

Patient Signature: ____ Date: __________

Healthcare Provider's Signature: ______________________________________ Date: __________