Obstetrics and Gynecology Associates of Central Florida
REGISTRATION SLIP

NAME _____ **DATE** _____
(last) (first) (middle)

ADDRESS _____ Apt#: _____ **MARITAL STATUS** _____

_____ **RACE** _____
(city) (state) (zip code) **ETHNICITY** _____

HOME # _____ **EMAIL** _____

CELL PHONE # _____

AGE _____ **DATE OF BIRTH** _____ **SOCIAL SECURITY #** _____

SPOUSE'S NAME _____ SS# _____

D.O.B. _____ SPOUSE PHONE# _____

PARENT'S NAME IF MINOR _____

PATIENT'S OCCUPATION _____

EMPLOYED BY _____
(name) (telephone) (ext.)

PHARMACY NAME: _____ PHARMACY PHONE #: _____

PHARMACY ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

PRIMARY PHYSICIANS ADDRESS: _____

MEDICAL INSURANCE

PRIMARY: Name of Insurance _____ Insured's Name _____

SECONDARY: Name of Insurance _____ Insured's Name _____

RELATIVE NOT LIVING IN YOUR HOME WHOM WE MAY CONTACT IN CASE OF EMERGENCY

NAME _____ PHONE # _____

ORDERED TEST:

__ (Int.) I understand that my provider at Obstetrics and Gynecology Associates of Central Florida, LLC may order additional services (Example: Blood Work, Ultrasound, mammogram, etc) and it is my full responsibility to check with my insurance regarding coverage prior to having test performed. Obstetrics and Gynecology Associates of Central Florida, LLC is not responsible for any non-covered services.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

__ (Int.) I authorize treatment of the person named above and agree to pay all fees charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentation thereof, unless prior arrangements have been made in writing prior to billing date.

It is agreed that payments will not be delayed or withheld because of any insuance coverage or pendency of claims thereof, and proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for collection.

ASSIGNMENT OF BENEFITS:

__ (Int.) I hereby authorize Obstetrics and Gynecology Associates of Central Florida, LLC, to release to my insurance company or it representative any information including the diagnosis and the records of any treatment or examination rendered to me during one (1) year from date signed of such surgical or medical care. I also aurthorize and request my insurance company to pay directly to the above named Doctors the amount due me in my claim for basic medical, major medical and/or surgical treatment or services, by reason of such treatment or services rendered to:

__ (Int.) I agree that Obstetrics and Gynecology Associates of Central Florida LLC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____
(Please print name) (Signature)

Obstetrics & Gynecology Associates of Central Florida, LLC

Date:

HPV Testing

At Obstetrics and Gynecology Associates of Central Florida, LLC we pride ourselves on offering our patients the most advanced preventative care available. We now offer our patients the only FDA-approved high risk HPV test. This test is a highly sensitive viral test used in conjunction with a pap test for cervical cancer screening in woman. Persistent infection with high-risk human papillomavirus (HPV) is the primary cause of cervical cancer. Our providers, based on clinical judgment, will provide the HPV testing to patients. If you have any questions please speak with your provider.

_____ _____

Patient Signature Date

Obstetrics & Gynecology Associates of Central Florida, LLC

Date:

I, _____, give permission for the person(s) listed below, to accompany me in the exam room, to pick up **ANY** medical records on my behalf, and to speak with any employee over the telephone, **with the full knowledge that any and all past and present medical history may be divulged**. This consent for permission is active for 1 (one) year. Any changes to this consent should be submitted in writing.

_____ - Accept (If you checked Accept, please fill in names below)
_____ - Decline

_____	_____
First Name, Last Name	Relationship
_____	_____
First Name, Last Name	Relationship
_____	_____
First Name, Last Name	Relationship
_____	_____
Patient Signature	Date

Consent to Call

When sending artificial, prerecorded, or automated calls and text messages, receipt of prior written and/or oral consent is required by our practice. By signing below you are consenting Obstetrics and Gynecology Associates of Central Florida, LLC to send artificial, prerecorded, or automated calls/text messages to you the patient.

_____ _____

Patient's Signature Date

If you wish not to receive artificial, prerecorded, or automated calls/text messages, please sign below declining Obstetrics and Gynecology Associates of Central Florida, LLC to send.

_____ _____

Patient's Signature Date

_____ _____

Witness Signature Date

Obstetrics & Gynecology Associates of Central Florida, LLC

Date:

Medical Malpractice Insurance

Under Florida Law, physician are generally required to carry medical malpractice insurance or otherwise demonstate financial responsibility to cover potential claims for medical malpractice.

OUR PHYSICIANS HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.

This is permitted under Florida Law and subject to certain conditions. Florida Law imposes penalties against non insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida Law.

FLORIDA STATUTE 458.320 (5)(G)(1)

I, _____, have received and read the above statements.

Signature:_____
Date of Birth:_____

Date:

Obstetrics & Gynecology Associates of Central Florida, LLC
2400 North Orange Blossom Trail, Suite 300
Kissimmee, FL 34744
407-846-7200
Fax: 407-846-3989

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

Dated: _____

Patient or Patient's Representative Signature: _____

Print Patient's Name: _____

If signed by Representative, state name of Representative: _____

Relationship to Patient: _____

Today's Date: _____

Do you have any problems you would like to discuss with your health care provider today?

_____

Have you been diagnosed with any of the following conditions? Please CIRCLE all that apply.

Cancer

Breast cancer or BRCA testing
Ovarian cancer
Uterine (endometrial) cancer
Colon cancer
Skin cancer
Cervical Cancer
Other cancer: _____

Cardiac – Heart

Irregular Heartbeat
Heart Disease
High blood pressure
High cholesterol
Other: _____

Dermatology – Skin

Acne
Eczema or Psoriasis
Other: _____

Ear Nose or Throat – ENT

Hearing loss
Other: _____

Endocrinology

Diabetes
Gestational Diabetes (during pregnancy)
Nipple Discharge
Bone Loss (Osteoporosis)
Thyroid Problems
Other: _____

Eyes

Cataracts
Glaucoma
Loss of sight (Macular Degeneration)

Infectious Disease

Chicken Pox or Shingles
HIV
MRSA
Rheumatic Fever
Tuberculosis (TB)
Unusual Childhood Disease
Other: _____

Neurology – Nerve Problems

Headaches or Migraines
Memory Loss or Dementia
Neuropathy or Nerve Pain
Seizures or Epilepsy
Stroke
Other: _____

Orthopedic

Chronic Back Pain
Degenerative Joint Disease
Fractures or Broken Bones
Other: _____

Psychiatric

Attention Deficit Disorder (ADD)
Anxiety Disorder
Bipolar Disease
Depression
Eating Disorder
Premenstrual Syndrome (PMS) or PMDD
Other: _____

Pulmonary

Asthma
COPD or Emphysema
Seasonal Allergies
Sleep Apnea
Other: _____

Gastrointestinal (GI)

Colon polyps
Crohn's or Ulcerative Colitis
Gallbladder Disease
Hemorrhoids
Irritable Bowel Syndrome (IBS)
Liver Disease or Hepatitis
Stomach Ulcers – Reflux (GERD)
Other: _____

Hematology – Blood Disorders

Anemia – Low Blood Count
Bleeding Disorder
Blood Clotting Disorder
Blood Transfusion
Deep Vein Thrombosis (DVT) or Pulmonary Embolism
Other: _____

Rheumatology

Arthritis (Osteo or Rhematoid)
Autoimmune Disorder or Lupus
Fibromyalgia or Chronic Pain
Restless Leg Syndrome
Other: _____

Urology

Frequent Urinary Tract Infections
Bladder Infections
Blood in the Urine (Hematuria)
Interstitial Cystitis
Kidney Disease
Kidney Stones
Urinary Incontinence or Uncontrollable Loss of Urine
Other: _____

List any and all surgery you have had and the approximate dates of the surgery.

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

List all Allergies to Medication:

_____
_____
_____

Are you Allergic to Latex: **YES OR NO**

List all medications you take **(Including over the counter medicines and vitamins).**

_____ _____
_____ _____
_____ _____

1 Last menstrual period? _____
2 Age of first menstrual period? _____
3 What age did you become sexually active? _____
4 Last Pap Smear? _____
5 Total number of lifetime partners? **Less than 5** **More than 5**
6 History of abnormal Pap Smear? **YES OR NO**
7 Are you sexually active currently? **YES OR NO**

8 Have you ever been diagnosed with a Sexually Transmitted Disease? **YES OR NO**

9 Are you trying to become pregnant? **YES OR NO**

10 Are you in a relationship? **YES OR NO**

11 What is your form of birth control?

NONE - CONDOMS - BIRTH CONTROL PILLS - IUD - HYSTERECTOMY - OTHER

12 List the number of previous pregnancy:

____ **Living Children** ____ **Miscarriage** ____ **Abortion**

Does anyone in your close family have the following conditions?

		Relative: (Please specify Maternal or Paternal)
1.	Heart Disease or Stroke: **Yes or No**	
2.	High Blood Pressure: **Yes or No**	
3.	Diabetes: **Yes or No**	
4.	Cancer: **Yes or No**	
5.	Breast Cancer: **Yes or No**	
6.	Uterine Cancer: **Yes or No**	
7.	Ovarian Cancer: **Yes or No**	
8.	Colon Cancer: **Yes or No**	
9.	Other Serious Illness: **Yes or No**	
10.	Blood Clotting Disorders **Yes or No**	

P Smoke cigarettes? **YES OR NO**

Packs per day? _____ **Years?** _____

2 Drink Alcohol? **YES OR NO**

Drinks per day? _____ **Per Week?** _____

3 Street Drug Use? **YES OR NO**

4 Caffeinated beverages? **YES OR NO**

5 Do you exercise regularly? **YES OR NO**

6 Seat Belt Use? **YES OR NO**

7 Do you work outside of the home? **YES OR NO**

8 What is your highest level of education? _____

9 What type of work do you do? _____

10 What is your religious affiliation? _____

11 Is a blood transfusion acceptable to you in an emergency situation? **YES OR NO**

12 History of Domestic Violence? **YES OR NO**

13 Marital Status? **Single Married Divorced Widowed Partner**

_____ _____

Patient Signature Date

_____ _____

Provider Signature Date