Demographics

First Name:_____ MI:____ Last Name:_____

SS#:_____ Date of Birth_____ Age:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____Cell Phone_____Work Phone_____

Employer:_____ Occupation:_____

Best Number to reach you: ____Home ____Cell ____Work

Patient Email:_____

Marital Status:

____ Single ____Married ____Divorced ____Widowed ____Separated

Emergency Information:

Emergency Contact Name: _____

Relationship:_____ Phone Number:_____

Emergency Contact Name: _____

Relationship:_____ Phone Number:_____

Primary Care Physician

Name:_____

Phone:_____ Fax:_____

Pharmacy Information:

Name:_____ Phone number: _____

Address:_____ Store #:_____

Signature:_____ **Date:**_____

WOMEN'S HEALTH SPECIALISTS OF CENTRAL FLORIDA

Name:_____ **Date of Birth:**_____

Reason for today's visit: (Circle One)

Annual Exam Pelvic Pain Post Menopausal Bleeding Abnormal Pap

Abnormal Bleeding Abnormal Imaging Birth Control Consult about Surgery STD

Other:_____

ALLERGIES:

_____

OB History:

Total number of pregnancies:____ Total Living:____ Miscarriages:____

Abortions____ Multiples____

Number of Vaginal Deliveries____ Number of C-Sections____

GYN History:

Last Menstrual Cycle:_____ Sexually Active: Yes No

Age at Menarche:____ HPV: Positive Negative HPV Vaccination: Yes No

Birth Control Method:(circle one)

Tubal Ligation Condoms Oral Contraceptives Depo-Provera

IUD Nexplanon/Implanon Nuva Ring Other:_____

Last Pap:_____ Abnormal: Yes No If Yes, Describe:

_____

Last Mammo:_____ Abnormal: Yes No If Yes, Describe:

_____

Last Dexa Scan:_____ Abnormal: Yes No If Yes, Describe:

_____

Last Pelvic Ultrasound:_____ Abnormal: Yes No If Yes, Describe:

_____

History of STD: Yes No If Yes, Describe:

_____

History of Endometriosis: Yes No

History of Fibroids: Yes No

History of Cyst: Yes No

History of Infertility: Yes No

History of PCOS: Yes No

History of Cervical Dysplasia: Yes No

History of Ovarian Problems: Yes No

WOMEN'S HEALTH SPECIALISTS OF CENTRAL FLORIDA

Name:_____ Date of Birth:_____

Surgical History:

List Surgeries	Year
1.	
2.	
3.	
4.	
5.	

Medical Conditions:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Medication List: (please include dosage)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Family History (please circle all that apply)

Breast Cancer Ovarian Cancer Uterine Cancer

Cervical Cancer Colon Cancer Melanoma

Diabetes Stroke Epilepsy Anemia Asthma

High Blood Pressure High Cholesterol

Migraines Hypo/Hyperthyroidism

Social History:

Yes No	Smoking
Yes No	Drinking
Yes No	Illegal Drugs
Yes No	Exercise
Yes No	Ever been Sexually Abused

BHRT Checklist For Women

Name: _____ Date: _____

E-Mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

WOMEN'S
HEALTH SPECIALISTS
OF CENTRAL FLORIDA

Acknowledgment of receipt of Notice of Privacy Practice.

I have received a copy of this office's Notice of Privacy Practice.

_____

Please Print Name

_____

Signature Date Of Birth

_____

Date

Please list the names of anyone who the office staff may release information to on your behalf. If they are not in this list no information will be released regarding your care or condition.

Name	Relation to Patient
_____	_____
_____	_____
_____	_____

_____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to accept Notice.
_____ Individual refused to sign Acknowledgement
_____ Individual was unable to sign.
_____ An emergency situation prevented us from obtaining acknowledgment.
_____ Other:

_____

_____

Employee Signature Date

WOMEN'S
HEALTH SPECIALISTS
OF CENTRAL FLORIDA

Cancellation Policy/No Show Policy for Doctor Appointments and Surgery

1.Cancellations/ No Show Policy for Doctors Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to seemingly "full' appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a thirty-five dollar ($35) fee; this will not be covered by your insurance company.

2.Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled appointment time we will have to reschedule the appointment.

3. Cancellation/ No Show Policy for Surgery

Due to the lard block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

4. Account Balances

We will require that patients with self pay balances do pat their account balance to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____	_____	____/____/____
Print Patient Name	Signature Patient/Guardian	Date

WOMEN'S
HEALTH SPECIALISTS
OF CENTRAL FLORIDA

I understand that it is my responsibility to provide Women's Health Specialist of Central Florida with documentation of any prior or current abnormal gynecological or medical test result/information which may be pertinent for my continued care. These documentation includes: pap smears, mammograms, ultrasounds, laboratory test, biopsies, CT scans, MRIs, Hospital records ect. In addition, if my medical history changes at any time I will inform the staff.

Print: _____

Signature: _____

Date: _____

Authorization for Release of Medical Records

To: _____

_____

Phone no._____ Fax no. _____

I _____ hereby authorize to disclose information from my medical records, as well as other data pertinent to your treatment of me to:

Dr. Silpa Senchani, M.D, FACOG
Women's Health Specialists of Cetral Florida
3131 Innovation Dr. St. Cloud, FL 34769
Phone: (407) 498-0071 Fax: (407) 498-0073

Specific information to be released: _____

This information is needed for the following reason: _____

_____ _____
Print name Date of birth

_____ _____
Patient or Legal Guardian Signature Date

_____
Witness

This Medical Record may contain information about drug abuse, alcoholism, venereal disease, abortion, mental health treatment, HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be release.

__ I DO consent to have this information disclosed.

__ I DO NOT consent to have this information disclosed.

Signature:_____ Date:_____