GEMINI
OBSTETRICS/GYNECOLOGY, LLC

*Todd M. Goldberg, D.O., F.A.C.O.O.G.*
*Douglas Smith, D.O., F.A.C.O.O.G.*
*Suzette M. Rodriguez, M.D., F.A.C.O.G.*

Dear Patient,

In an effort to provide the best experience during your office visit today, please take a few minutes to complete the following questions. It will help us keep current on very important health issues affecting you and it will allow the most efficient use of time with the Doctor. Thank you!

**CONTRACEPTION**

1. Are you currently using contraception (birth control)? Yes___ No___
2. If so, what form of Birth Control are you using? _____
3. Would you like information on a non-hormonal, permanent birth control option? performed in the comfort of our office? Yes___ No___
4. Are you interested in an IUD? Yes___ No____ with or without Hormones? _____

**VACCINATIONS**

1. Have you been vaccinated for Tetanus and/or Pertussis? Yes ___ No___
2. Have you been vaccinated for HPV? Yes ___ No ___

**MENSTRUAL PERIODS**

1. How long does your average monthly period last? _____days
2. Do you ever feel as though your periods impact the quality of your life? Yes___ No__
3. Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods? Yes___ No___

**URINARY HEALTH**

1. Do you ever leak urine when you cough, laugh or sneeze? Yes___ No___
2. Do you ever feel as though you have to urinate urgently? Yes___ No___
3. Do you feel like you have to urinate too frequently? Yes___ No___
4. Do you ever experience painful urination? Yes___ No___

**PERSONAL HEALTH**

1. Are you interested in more information about our weight loss programs? Yes___ No___
2. Are you interested in bioidentical hormone therapy? Yes___ No___
3. Are you interested in Botox or Dermal fillers? Yes ___ No___

**Please print your first and last name** _____

**Date Completed** _____

Date _____
*Fecha*

# Patient Registration
## *Registración del Paciente*

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

## Patient Information - *Información del Paciente*

Social Security # _____
*Numero de Seguro Social*
First Name _____ Middle _____
*Primer Nombre* *Segundo Nombre*
Last Name _____
*Apellido*
Sex _____ Date of Birth ____/____/____
*Sexo* *Fecha de Nacimiento*
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed
*Estado Civil* *Casada* *Soltera* *Divorciada* *Viuda*

(Check One) ☐ Employed ☐ Retired ☐ Full-Time Student
*Marque Uno* *Empleada* *Retirada* *Estudiante Tiempo Completo*
☐ Other _____
*Otro*
Employer _____
*Empleador*

Home Address _____
*Direccion del Hogar*
_____
City _____ State _____ Zip _____
*Ciudad* *Estado* *Codigo Postal*
Email Address _____
Home Phone (_____) _____
*Telefono del Hogar*
Work Phone (_____) _____
*Telefono del Trabajo*
Cell Phone (_____) _____
*Telefono Cellular*
Referring Physician _____
*Referida Por el Dr:*
How did you hear of us? _____
*Como usted supo de nosotros?*

## Insurance Information - *Información del Seguro*

**Please provide your insurance card to the receptionist** - *Por favor entregue su tarjeta de seguro a la recepcionista*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other _____

Insurance company _____
*Compañia de Seguro*
Insured / Card Holder's Name _____ Relationship _____
*Nombre del Asegurado* *Relación*
Policy # _____ Group # _____ Phone (  ) _____
*Numero de Poliza* *Numero de Grupo* *Telefono*

## Secondary Insurance Information - *Información del Seguro Secundario*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other _____

Insurance company _____
*Compañia de Seguro*
Insured / Card Holder's Name _____ Relationship _____
*Nombre del Asegurado* *Relación*
Policy # _____ Group # _____ Phone (  ) _____
*Numero de Poliza* *Numero de Grupo* *Telefono*

## Emergency Contact - *En Emergencias, contactar a:*

First Name _____ Middle _____ Home Phone (_____) _____
*Primer Nombre* *Segundo Nombre* *Telefono del Hogar*

Last Name _____ Work Phone (_____) _____
*Apellido* *Telefono del Trabajo*

## Spouse / Guarantor / Responsible Party - *Esposo / Persona Responsable*

Social Security # _____ Sex _____ Date of Birth ____/____/____
*Numero de Seguro Social* *Sex* *Fecha de Nacimiento*
Relationship _____ DAYTIME PHONE (_____) _____
*Relación* *Teléfono durante el dia*
First Name _____ Middle _____ EMPLOYER _____
*Primer Nombre* *Segundo Nombre* *Empleo*
Last Name _____ ADDRESS _____
*Apellido* *Direccion*
Address _____ CITY _____ STATE _____ ZIP _____
*Direccion* *Ciudad* *Estado* *Codigo Postal*
City _____ State _____ Zip _____
*Ciudad* *Estado* *Codigo Postal*



**Signature Required Please See Reverse Side**

## FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos ciertas tarjetas de credito. Su seguro medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to S.458.320 (5)(g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida law.

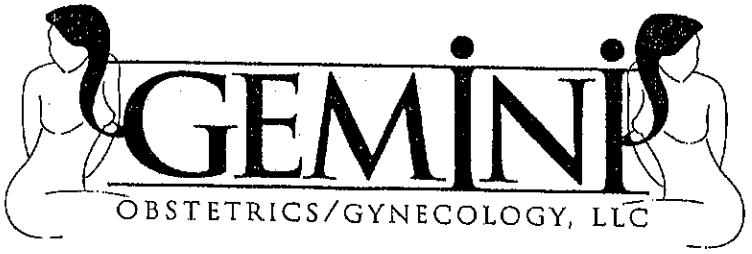
Hemos elegido no llevar seguro de negligencia medica o no demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (la ley 5) (g). Florida impone penas contra los medicos de los no-asegurado que no pueden satisfacer los juicios adversos que se presentan de demandas de la negligencia medica. Este aviso esta conforme a la ley de la Florida.

## PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by the physician. I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a el medico todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsible por todos los cargos no cubiertos bajo mi seguro medico.

PATIENT'S / GUARANTOR'S SIGNATURE _____ DATE _____




Todd Goldberg, D.O. FACOOG Douglas Smith, D.O. FACOOG Suzette Rodriguez, M.D. FACOG
603 N. Flamingo Road/Suite 361, Pembroke Pines, Florida 33028 – Phone #954-432-7900/Fax: 954-433-4903
2300 N. Commerce Pky/Suite 205, Weston, Florida 33326 – Phone #954-389-3855

## Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Gemini OB/GYN, LLC to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Gemini OB/GYN, LLC.

I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am financially responsible for all charges including costs of collection and litigation if necessary.

Date_____ Signature_____
(patient, parent, or guardian)

## Physician Financial Responsibility

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non insured physicians who fail to satisfy adverse judgment arising from claims of medical malpractice. This notice is pursuant to Florida law.

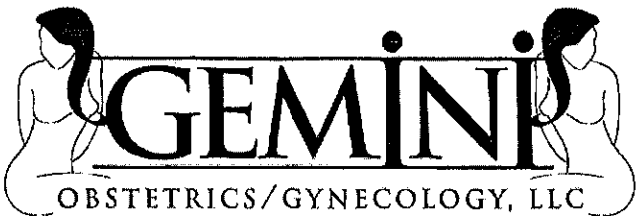
Date_____ Signature_____
(patient, parent, or guardian)

## Medical Malpractice Agreement

Further, I understand that I am entering into a contractual relationship with Gemini OB/GYN, LLC for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Gemini OB/GYN, LLC, I (the patient) and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Gemini OB/GYN, LLC.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as Gemini OB/GYN, LLC. Furthermore, I agree that these expert witness(es) will adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, Gemini OB/GYN, LLC, agree to the same stipulations.

_____ _____
Date Patient

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2300 N. Commerce Pky/Suite 205, Weston, Florida 33326 – Phone #954-389-3855

# PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge that there was a copy of the Notice of Privacy Practices posted describing how my health information may be used or disclosed under the federal law. Provided that "Gemini OB/GYN, LLC continues in its good faith effort to comply with the requirements of the federal privacy act law, I hereby consent to the use and disclosure of my health information for the purposes and the activities permitted under the federal privacy law, which are described in the Notices of Privacy Practices.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the notice may be changed at any time. I may obtain a revised copy of the notice by calling (954)-432-7900 or by requesting one while at your office.

I also authorize Dr. Todd M Goldberg, DO, Dr. Douglas Smith, DO and Dr. Suzette M Rodriguez, MD and staff to release all medical information to the following:

| | | | |
|---|---|---|---|
| Name | Date | | Relationship to Patient |
| Name | Date | | Relationship to Patient |
| Patient Name Printed | Date | | Signature of Patient |

# Cancer Family History Questionnaire

## Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F):_____ Today's Date(MM/DD/YY):_____ Health Care Provider:_____

### Your Personal & Family History of Cancer Is Important to Provide You With the Best Care Possible

Please mark "Yes" or "No" below if there is a **personal or family history** of any of the following cancers.
If yes, indicate family relationship and age at diagnosis in the appropriate column.
**Include both sides of your family and list each member separately:** parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, and half-siblings.

| Personal and Family History<br>Have you or your family members been diagnosed with any of the following: | | YOU | SIBLINGS / CHILDREN | MOTHER'S SIDE | FATHER'S SIDE |
|---|---|---|---|---|---|
| | | Age | Family Member and Age | Family Member and Age | Family Member and Age |
| **EXAMPLE:** Breast cancer | ☒ Y ○ N | Age 49 | Sister 55, Daughter 33 | Aunt #1 67<br>Aunt #2 45 | Grandma 84 |
| **Breast cancer** at or before age 45 | ○ Y ○ N | | | | |
| 2 or more separate **breast cancers** in one person, one at age 50 or younger | ○ Y ○ N | | | | |
| 2 or more people on the same side of my family (can include me) with **breast cancer**, one at age 50 or younger | ○ Y ○ N | | | | |
| **Ovarian (peritoneal/fallopian tube) cancer** at any age | ○ Y ○ N | | | | |
| **Triple Negative Breast cancer** at age 60 or younger (ER-, PR-, HER2- Pathology) | ○ Y ○ N | | | | |
| 3 or more of these cancers on same side of my family at any age: **pancreatic, breast,** or **aggressive prostate*** *Gleason Score ≥7 | ○ Y ○ N | | | | |
| Male **breast cancer** at any age | ○ Y ○ N | | | | |
| Ashkenazi Jewish ancestry with **breast or pancreatic cancer** at any age | ○ Y ○ N | | | | |
| **Pancreatic cancer or aggressive prostate cancer** and one relative with **breast cancer at age 50 or younger** | ○ Y ○ N | | | | |
| 20 or more **colon/rectal polyps** found in 1 person throughout their lifetime. Specify number_____ | ○ Y ○ N | | | | |
| **Colon/rectal** or **Endometrial (uterine) cancer** before age 50 | ○ Y ○ N | | | | |
| Personal history of **Endometrial (uterine) cancer** at any age‡ | ○ Y ○ N | | | | |
| TWO individuals on the same side of my family (can include me): at least 1 with **colon/rectal *or* endometrial (uterine) cancer** at any age AND ALSO 1 diagnosed before age 50 with a Lynch-associated* cancer | ○ Y ○ N | | | | |
| THREE OR MORE individuals on the same side of my family (can include me) with a **Lynch-associated* cancer** at any age, with at least 1 being a colon/rectal or **endometrial (uterine) cancer** | ○ Y ○ N | | | | |

‡ $PREMM_{[1,2,6]}$ Score ≥ 5%
* Lynch-associated cancers include: colon, endometrial(uterine), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).

| | | |
|---|---|---|
| Have you or a family member had genetic testing for a **hereditary cancer syndrome**? | ○ Y ○ N | If yes, Who?_____ What gene(s)?_____<br>What was the result? _____ |

## Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

**Office Use Only**

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

If YES, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis* REFLEX to BRAC*Analysis* with Myriad myRisk

☐ COLARIS®PLUS with Myriad myRisk ☐ COLARIS *AP*®PLUS with Myriad myRisk ☐ Single Site Testing ☐ Myriad myRisk Update ☐ Other:_____

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:_____