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

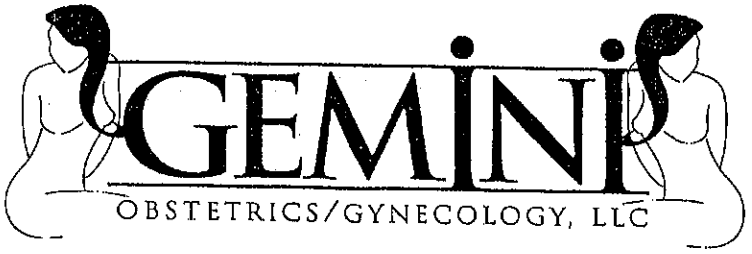
1. Do you ever leak urine when you cough, laugh or sneeze? Yes___ No___
2. Do you ever feel as though you have to urinate urgently? Yes___ No___
3. Do you feel like you have to urinate too frequently? Yes___ No___
4. Do you ever experience painful urination? Yes___ No___

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 _____



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.

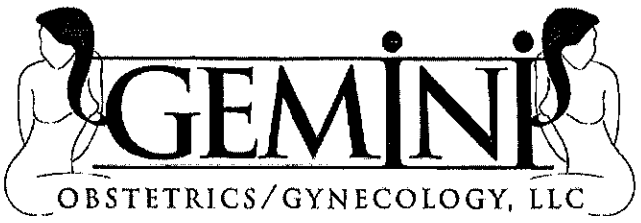
Date_____ Signature_____
(patient, parent, or guardian)

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



Todd Goldberg, D.O. FACOOG Douglas Smith, D.O. FACOOG Suzette Rodriguez, M.D. FACOG
603 N. Flamingo Road/Suite 301, 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

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 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 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)?_____ 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:_____