# Palm Beach Obstetrics & Gynecology

Please print and complete as accurately as possible

Date:_____

Name:_____
Last First Middle

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Permanent Address:_____

City:_____ State:_____ ZIP:_____ Phone:( )_____

Birthdate:_____/_____/_____ Social Security No._____-_____-_____
Mo Day Yr

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Race: ☐ White ☐ African-American ☐ Asian ☐ Amer Indian/Alaskan ☐ Pacific islander ☐ Other

E-mail address:_____ Cell Phone:( )_____

Pharmacy name: _____ City:_____ Phone: ( )_____

Who referred you to us?_____

Primary Care Provider:_____

Preferred communication: ☐ E-mail ☐ Phone ☐ Text ☐ Mail

EMERGENCY CONTACT

Name:_____ Relation:_____

Phone:( )_____

EMPLOYER INFORMATION

Name of Employer:_____ Phone:( )_____

INSURANCE INFORMATION

Insurance:_____

Claims Address:_____

City:_____ State:_____ ZIP:_____ Phone:( )_____

ID #:_____ Group #:_____

Policyholder name:_____

Policyholder Birthdate:_____/_____/_____ Social Security No._____-_____-_____
Mo Day Yr

Does your insurance require a referral ? ☐ Yes ☐ No

# Palm Beach Obstetrics & Gynecology

## Financial Policy

The following information is provided to make our financial policies clear and avoid any possible misunderstandings concerning the payment for professional services.

Insurance
Our practice participates in a variety of insurance plans. It is your responsibility to:

- Bring your Insurance Card to every visit
- Be prepared to pay for any co-pays, co-insurance and/or deductibles that apply.
- Payment in full is due at the time of service for any medical care not covered by your insurance. You are responsible for any balance if your insurance denies all or part of the claim.

Annual exams
Many insurance policies cover annual exams differently from sick/problem visits. Some may not cover preventive care at all, and some may pay 100% up to a certain amount. When we bill your insurance company, the codes we submit must be consistent with nationally accepted coding practices. This means we cannot bill a visit with incorrect codes just to get the claim processed in your favor. If you discuss a problem with your doctor during the annual visit, we are obligated ethically and by our agreements with your insurance company to document and bill for your visit properly. This means that we may have to bill for both the annual visit as well as the problem visit, and you may be responsible for any copays or deductibles.

Self-Pay patients

- Payment for office visits is due at the time of service.
- A payment plan is available for obstetrical care and for surgical procedures. Please ask to speak with our Administrator for details.

Referrals
It is the patients' responsibility to bring any required referrals for treatment at the time of the visit. If a referral is not available, the appointment may have to be rescheduled.

Lab fees
Please be aware that lab fees for blood work and pathology (tissue samples including PAP smears) are separate from our office charges and may be billed directly to you by the lab company.

Electronic prescriptions
Our practice uses electronic prescribing. Your prescriptions will be sent and your medication information (including formulary benefits) may be obtained through our computerized electronic prescribing function.

Insurance coverage is complex and each policy is different. If you have any questions about your insurance, we are happy to help you. Details regarding your particular coverage must be directed to your Insurance Company's Member Services Department. Their number is usually found on the back of the insurance card.

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Palm Beach Obstetrics & Gynecology PA for services rendered. I understand that I am responsible for all charges not covered by my medical insurance. In addition, I am responsible for any deductible, co-pay and co-insurance amounts.

_____ _____

Signature Date

# Palm Beach Obstetrics & Gynecology, PA

## Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize Palm Beach Obstetrics & Gynecology to use and/or disclose the protected health information described below to _____.
[Name of Individual]

2. Authorization for Release of Information. Covering the period of health care of

☐ all past, present and future periods OR FROM ☐ _____ to _____

a. ☐ I hereby authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

b. ☐ I hereby authorize the release of my complete health record with the exception of the following information:

☐ mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

3. The person I authorize may use this medical information for medical treatment or consultation, for billing or claims payment, or for other purposes as I may direct.

4. This authorization shall be in force and effect until _____, at which time this authorization expires.
[Date]

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Relationship to Patient

# Palm Beach Obstetrics & Gynecology
## Personal History-Gynecology

Name:_____ Date:_____

Date of Birth: _____

This part of the medical record is strictly confidential. It will not be released to any other person or entity without your written authorization.

### 1. Past Medical History:

[ ] High blood pressure
[ ] Heart disease
[ ] Diabetes
[ ] Hepatitis
[ ] Anemia
[ ] Leg blood clots
[ ] Lung blood clots
[ ] Blood transfusions
[ ] Stroke
[ ] Skin cancer
[ ] Skin fungus
[ ] Other skin problems
[ ] Breast cancer

[ ] Vaginal warts
[ ] Sexually transmitted diseases
[ ] Uterine fibroids
[ ] Abnormal PAP smears
[ ] PMS
[ ] Genital Herpes or blisters
[ ] Oral Herpes or blisters
[ ] Osteoporosis
[ ] Endometriosis
[ ] Bladder infections
[ ] Kidney problems
[ ] Bone fractures
[ ] Other cancer (type)_____

[ ] Seizures
[ ] Depression
[ ] Psychiatric problems
[ ] Thyroid disease
[ ] Irritable bowel
[ ] Stomach ulcers
[ ] Arthritis
[ ] Headaches
[ ] Asthma
[ ] Pneumonia
[ ] Radiation treatment
[ ] Sickle cell disease

[ ] Other_____

### 2. Surgeries: [ ] None

| | Year | | Year | | Year |
|---|---|---|---|---|---|
| [ ] Hysterectomy | _____ | [ ] C-Section | _____ | [ ] Tubal ligation | _____ |
| [ ] Appendix removal | _____ | [ ] Gallbladder | _____ | [ ] D&C | _____ |
| [ ] Tonsil removal | _____ | [ ] Knee surgery | _____ | [ ] Breast biopsy | _____ |
| [ ] Cosmetic surgery | _____ | Type_____ | | | |

[ ] Other_____

### 3. Medications: [ ] None

| | Name/Dose | | Name/Dose |
|---|---|---|---|
| [ ] Birth control pills | _____ | [ ] Heart | _____ |
| [ ] Blood pressure | _____ | [ ] Hormones | _____ |
| [ ] Thyroid | _____ | [ ] Vitamins | _____ |
| [ ] Aspirin | | [ ] Insulin | |

[ ] Other _____

### 4. Allergies: [ ] None

[ ] Penicillin
[ ] Tape
[ ] Other: _____

[ ] Sulfa
[ ] Latex

[ ] Tetracycline
[ ] Foods

### 5. Family history: [ ] Unknown Parents, grandparents and siblings only

Please write which family member next to diagnosis

[ ] Cervical cancer
[ ] Uterine cancer
[ ] Ovarian cancer
[ ] Breast cancer
[ ] Osteoporosis
[ ] Other cancer (type)_____
[ ] Other_____

[ ] Heart disease
[ ] High blood pressure
[ ] Stroke
[ ] Sickle cell
[ ] Kidney problems

[ ] Diabetes
[ ] Leg or lung blood clots
[ ] Colon cancer
[ ] Mental illness
[ ] Genetic problems

## 6. Menstrual history:

In menopause [ ] Yes [ ] No Age of menopause:_____

If already in menopause, please go to section 8

Age of first period:_____ Number of bleeding days:_____

Days between periods:_____

Flow: [ ] Light [ ] Medium [ ] Heavy [ ] None

Date of last menstrual period:_____

## 7. Contraception:

[ ] None

[ ] Tubal ligation
[ ] Condoms
[ ] IUD, Type_____
[ ] Depo-Provera shots
[ ] Vaginal ring
[ ] Birth control pills - Name_____
[ ] Vasectomy
[ ] Foam
[ ] Suppository
[ ] Patch
[ ] Other_____
[ ] Rhythm
[ ] Diaphragm
[ ] Sponge
[ ] Withdrawal

## 8. Pregnancy history:

[ ] None

Please complete as completely as possible

| | Number | Year(s) |
|---|---|---|
| [ ] Miscarriages | _____ | _____ |
| [ ] Abortions | _____ | _____ |

| Year | Sex | Type of delivery: Vaginal | Type of delivery: C-Section | Complications |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## 9. Social History:

[ ] None

| YES | NO | | Former | Current | Amount |
|---|---|---|---|---|---|
| [ ] | [ ] | Tobacco | [ ] | [ ] | _____ |
| [ ] | [ ] | Alcohol | [ ] | [ ] | _____ |
| [ ] | [ ] | Drugs | [ ] | [ ] | Name:_____ |

[ ] [ ] Regular exercise
[ ] [ ] Safety concerns at home/Domestic violence

[ ] [ ] Vaccination for HPV infection (Gardacil™ or Cervarix™)
[ ] [ ] Vaccination for Hepatitis

[ ] [ ] Have you completed an Advance Directive for Health Care (ADHC), Living Will, or POLST (Physician Orders for Life Sustaining Therapy)?

Reason for your visit today _____