Aventura OBGYN Associates | Hallandale OBGYN | Elite OBGYN

Diplomates of the American Board of Obstetrics and Gynecology
*B. Mitchell Grabois, M.D., F.A.C.O.G. * Mark A. Firestone, M.D., F.A.C.O.G. * Liza I. Lizarraga O., M.D., F.A.C.O.G., MPH * Sweta Mehta D.O., F.A.C.O.O.G. * Melissa Kushlak, D.O., F.A.C.O.O.G. * Vivian Chona, APRN-C * Yessy Felipe, APRN-C*

Patient Information Form

Date: _____

First name:_____Middle:_____Last:_____

Date of Birth:_____SSN:_____

Address:_____Unit/Apt_____

City:_____State:_____Zip:_____

Phone:
Home:(_____)_____Cell:(_____)_____

Email:_____

Employer:(_____)_____Work Phone:(_____)_____

Marital Status:_____Religion:_____Ethnicity:_____

Language: _____Assigned Sex at Birth:_____

Sexual Orientation:_____Gender Identity: _____

Emergency Contact:_____Phone:_____Relation:_____

Allergies:_____

Primary care Doctor:_____Phone:(_____)_____

Referred by:_____

Do you Have a living Will? Yes or No _____

Insurance: 1)_____2)_____

Guarantee of Payment

I fully understand that I am directly responsible for the payment to the physician's office for all medical and surgical services rendered to me. I also understand that bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs, including reasonable attorney's fees and costs, in the event it becomes necessary to file a suit to effect payment.

I hereby authorize the providers in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing my insurance claims.

If this office files any claims on my behalf, I hereby authorize direct payment of any benefits to the providers in this office for medical or surgical treatment received by me. I understand that I am financially responsible for any co-payments, co-insurance, deductibles and/or any charges not covered by my insurance**. If I do not provide the office with 24 hours cancellation notice, I will be responsible for a $25.00 fee**.

I understand that benefits quoted by my insurance company are an estimate and not a guarantee of payment. The ultimate decision for payment will be reached when my insurance processes the claim.

X _____

Patient Signature- If you are a minor, a parent or guardian must sign.

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Acknowledgement of Privacy Practices

I acknowledge and have read the Notice of Privacy Practices of the Medical Practice(s) named at the top of this page.

Print Name of Patient: _____

Signature of Patient: _____ Date: _____

Patient's Date of Birth: _____

**If patient has a personal representative:

Print Name of Personal Representative: _____

Describe Personal Representative Relationship (Parent, guardian, etc):
_____

Signature of Personal Representative: _____Date: _____

Below space is for Office use only:

_____
_____
_____
_____
_____

_____ _____

Signature of Office Employee Date

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Wellness Exam Notice

Welcome to the office of Aventura OBGYN & Associates, Hallandale OBGYN and Elite OBGYN. This letter is to inform you that most health plans only cover one (1) Annual Wellness Exam per year (one visit as a Well Woman in a 365-day period).

For most insurance plans, a Wellness exam consists of the following evaluation:

1. A General Gynecological Exam
2. A PAP Smear
3. Renewal of Contraceptives or Hormone Replacement

NOTE: You will need a referral for any new starts of Birth Control or Hormone Replacement Therapy

** The Wellness exam only covers the cost of being evaluated by the physician if you have NO PROBLEMS, COMPLAINTS, SYMPTOMS, MISSING PERIODS, ETC. If the doctor should evaluate a problem regarding ANYTHING other than what is included in a Well Patient Exam, such as Menopause, Infection, Hormone Problems, Infertility, etc., the patient will be responsible to pay the amount required by their insurance plan before being seen. Some insurances may also require patient to obtain a referral from their primary care physician before the doctor can further evaluate anything other than what is included in a Wellness exam.

Thank you for your cooperation with this matter,

The physicians and staff of Aventura OBGYN Associates, Hallandale OBGYN and Elite OBGYN

Please sign acknowledging you read and understand this form:

Print Patients Name: _____

Patients Signature: _____

Today's Date: _____

Witness (for office staff only):

_____

MYRIAD myRisk® Hereditary Cancer

Cancer Family History Questionnaire

Personal Information			
Patient Name	**Date of Birth**	**Healthcare Provider**	**Today's Date**

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know.
The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, **ovarian**, or **pancreatic cancer** at any age	☐ Y ☐ N		
Colorectal or **uterine cancer** at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two **breast cancers** (bilateral) in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three **breast cancers** in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with **breast cancer** at any age	☐ Y ☐ N		☐ M ☐ P	
Do you have a family history of **other cancers**?	☐ Y ☐ N	**List them here:**		
Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	**Who?**	**What gene(s)?**	**What was the result?**

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)

Patient Signature _____ Date _____

Healthcare Provider 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: _____

Pelvic Health Survey

Today's date: _____
Patient's Name: _____ Age: _____

Bladder (check one):

1. How often do you leak urine (check one box)?
   - 0 □ Never
   - 1 □ About once a week or less often
   - 2 □ Two or three times a week
   - 3 □ About once a day
   - 4 □ Several times a day
   - 5 □ All the time
2. We would like to know how much urine you think leaks. How much urine do you usually leak (whether you wear protection or not)? Check one box:
   - 0 □ None
   - 2 □ A small amount
   - 4 □ A moderate amount
   - 6 □ A large amount
3. Overall, how much does leaking urine interfere with your everyday life? Please circle a number between 0 (not at all) and 10 (a great deal).

0	1	2	3	4	5	6	7	8	9	10
Not at all										A great deal

ICIQ score: sum 1 + 2 + 3 = _____

4. When does urine leak? (please check all that apply to you)
   - □ Never (urine does not leak)
   - □ Leaks before you can get to the toilet
   - □ Leaks when you cough or sneeze
   - □ Leaks when you are asleep
   - □ Leaks when you are physically active/exercising
   - □ Leaks when you have finished urinating and are dressed
   - □ Leaks for no obvious reason
   - □ Leaks all the time

Do you wear diapers, pads, or panty liners because of leaking?	□ Yes	□ No
Are you bothered by the number of times per day you have to empty your bladder?	□ Yes	□ No
Do you wake up at night to empty your bladder?	□ Yes	□ No
If yes, How many times? _____		
Do you feel you have to rush to the toilet to avoid an accidental leak?	□ Yes	□ No

Bowel:

1. Do you accidentally leak stool?	□ Yes	□ No
2. Do you have to strain to have bowel movements?	□ Yes	□ No
3. Do you pass gas when you do not want to?	□ Yes	□ No

Gynecological:

1. Do you experience pelvic pain?	□ Yes	□ No
2. Do/did you experience pain with intercourse?	□ Yes	□ No
3. Do you have a feeling of a "ball" in your vagina?	□ Yes	□ No
4. Hysterectomy?	□ Yes	□ No
5. Vaginal dryness?	□ Yes	□ No
6. # of vaginal deliveries _____		
7. # of Cesarean Sections _____		