



PATIENT INITIAL INTAKE AND SELF HISTORY - Page 1

Date of Appointment: _____

Name: _____

Date of Birth: _____

Reason for today's visit:

ALLERGY HISTORY <input type="checkbox"/> None <input type="checkbox"/> Medication (list below) <input type="checkbox"/> Latex <input type="checkbox"/> Seasonal <input type="checkbox"/> Other:			
Medication	Reaction	Medication	Reaction

CURRENT MEDICATIONS <input type="checkbox"/> I give my consent for My Ob/Gyn LLC to electronically obtain my medication history			
PHARMACY _____		Phone: _____	Fax: _____
Medication	Dose	Medication	Dose

PREVIOUS TESTS			
Last Pap Smear date: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal, explain: _____	
Last Mammogram: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal, explain: _____	
Last Bone Density: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal, explain: _____	
Last Colonoscopy: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal, explain: _____	

PERSONAL HABITS			
Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Former Cigarette, Packs/Day _____ # Years _____ Yr Started _____ Yr Quit: _____ <input type="checkbox"/> Current Cigarette, Packs/Day _____ # Years _____ Yr Started _____ <input type="checkbox"/> Other Tobacco, specify _____			
Alcohol Use: <input type="checkbox"/> None <input type="checkbox"/> Social/Holiday <input type="checkbox"/> Weekly, specify _____ <input type="checkbox"/> Daily, specify _____			
Exercise: _____			
Special Diet: <input type="checkbox"/> None <input type="checkbox"/> Vegetarian <input type="checkbox"/> Kosher <input type="checkbox"/> Other _____			
Recreational Drug Use: <input type="checkbox"/> Never <input type="checkbox"/> In Past <input type="checkbox"/> Currently using <input type="checkbox"/> Rec'd treatment for substance abuse <input type="checkbox"/> IV Drug Use			

SURGICAL HISTORY			
Year	Surgery with Diagnosis or Problems	Year	Surgery with Diagnosis or Problems

PAST MEDICAL HISTORY Page 2

Problem	Now	Past	N/A	Notes	Problem	Now	Past	N/A	Notes
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Abnormal Vaginal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Abnormal Pap Smears / HPV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Breast disease, specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Heart disease/murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer, specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes or Gestational Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Gastrointestinal disorder, specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Pelvic Inflammatory Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Kidney Infection/stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian Cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke CVA TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Disease, specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uterine Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Blood Clots/Thromboembolism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uterine Fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic Constipation or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic Headache or Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease, specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Accidents, Injuries or Fractures: _____

OTHER: _____

OTHER: _____

INFECTION HISTORY

Problem	Date/Notes	Problem	Dates/Notes
Yeast	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Mononucleosis	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Bacterial Vaginosis	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Gonorrhea	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Urinary Tract Infections	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Chlamydia	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Trichomoniasis	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Genital Warts	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Syphilis	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Pelvic Infection	<input type="checkbox"/> Y <input type="checkbox"/> N _____	HIV/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Hepatitis B	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Hepatiis C	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Chicken Pox	<input type="checkbox"/> Y <input type="checkbox"/> N _____

Do you / your partner have a history of STD, IV drug usage or male partner having sex with another man? N Y explain _____

If yes to the above question, do you use condoms consistently? Yes No, If not explain _____

GYNECOLOGIC HISTORY

Age at first menstrual period _____

Do you still have periods? Yes No

When was the first day of your last period? _____

Are they regular? Yes No, explain: _____

Menstrual flow is Heavy Moderate Light

How many days are in between your menstrual periods? _____ days

How many days long is your typical period? _____ days

Painful Periods? No Yes, describe: _____

Were you exposed to DES in utero? Yes No Uncertain

SEXUAL HISTORY Page 3

Are you currently in a sexual relationship? Yes No (Virgin)

Steady Relationship? Yes, How long? _____
 NO How many partners in the last 12 mos? ____ In lifetime? _____

Sexual Preference ? Male Female Both

Last Intercourse date: _____

Are you planning a pregnancy in the next 12 months? Yes No

Do you have a history of rape? No Yes, if comfortable with details, please explain

CONTRACEPTION HISTORY

Current Birth Control: None, because Trying to get pregnant Vasectomy Tubes tied Post Menopausal
 Yes, my method is _____

Consistent in use? No Yes How long have you been using this method? _____

History of IUD / Implant? No Yes What Type? Paragard Mirena/Skyla Implanon Nexplanon

When and why discontinued? _____

OBSTETRIC HISTORY G: P:

Total #Pregnancies ____ #Full Term Vaginal ____ #C-Sections ____ #Premature ____ Total Living ____

#Miscarriages ____ at ____ weeks, with or without D&C, complications _____

#Abortions ____ at ____ weeks, complications _____

Year	Vaginal or Cesarean	Weight	Problems encountered before, during or after birth

FAMILY HISTORY Unknown, I am adopted

Mother Living Deceased, Cause _____ **Father:** Living Deceased, Cause _____

Siblings: Number Living ____ Number Deceased ____ Cause(s) _____

Place an "X" in each box for each problem	Heart Disease	Hyper-tension	Stroke	Diabetes (specify type)	Uterine, Cervical, Ovarian Cancer	Breast Cancer	Colon Cancer	Osteo-porosis	Fibroids	Other Significant Medical Problems
Mother										
Father										
Brother(s)										
Sister(s)										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										
Maternal Aunt(s)										
Paternal Aunt(s)										
Uncle(s)										
Children										

If yes for any **Breast Cancer**, has any family member don the BRCA test? _____

What age was the breast cancer discovered for each family member? _____

Does any family member have: Sickle Cell Bleeding disorder Genetic Disorder Twins Alcoholism Psychiatric

Explain any other pertinent medical problems in your family _____

REVIEW OF SYSTEMS **Page 4**

Please (✓) if you have experienced any of the following symptoms in the last 3 months

Symptom	✓	Notes	Symptom	✓	Notes
Chronic fatigue			Nausea or vomiting		
Fevers			Poor appetite		
Difficulty falling or staying asleep			Abdominal bloating/fullness		
Unintentional weight loss			Heartburn		
Unintentional weight gain			Constipation		
Rash			Diarrhea		
Itching			Blood in stools		
Vaginal or vulvar ulcers or fissures			Pain with bowel movements		
Itchy eyes			Urinary frequency		
Sore throat			Urgency (sudden urge to urinate)		
Mouth sores or ulcers			Urine leaking		
Bleeding gums			Pain with urination		
Chest pain			Blood in urine		
Irregular heart beat			Incomplete bladder emptying		
Ankle/foot swelling			Night time urination (>2/night)		
Shortness of breath			Vaginal discharge		
Chronic cough			Painful periods		
Wheezing			Painful intercourse		
Headaches			Vaginal dryness		
Dizziness			Irregular bleeding		
Low attention/difficulty concentrating			Breast Pain		
Muscle or joint pain			Breast mass		
Body aches and stiffness			Nipple discharge		
Leg pain			Hot flashes		
Back pain			Night sweats		
Trouble walking			Excess hair growth		
Other Symptoms					

RECENT VACCINATIONS

Last Flu Shot _____ Last Tdap _____ HPV vaccination _____ Last Pnuemonia _____

SAFETY

- 1) Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? Y N _____
- 2) Do you feel safe in your current relationship? Y N _____
- 3) Is there a partner from a previous relationship who is making you feel unsafe now? Y N _____

FOR MEDICARE PATIENTS, PLEASE ANSWER THE FOLLOWING

- 1) Pap smear in the last 7 years? N Y _____
- 2) Abnormal Pap smear? N Y when? _____
- 3) Ever tested positive for the HIV virus? N Y _____
- 4) Sexual activity before 16 years old? N Y _____
- 5) More than 5 sexual partners in lifetime? N Y _____
- 6) Mother take DES when pregnant with you? N Y _____

COMPLETED BY:

REVIEWED BY:

PATIENT SIGNATURE

Form Complete Date

PROVIDER SIGNATURE

DATE



Patient Demographic Page

Name: Date of Appointment: Date of Birth:

Address: Email

Who told you about this office?

Primary Physician: Phone: Fax:

Marital Status: Single Divorced Separated Widowed Married, Husband/Partners Name:

Racial Background: White Black or Afro American American Indian/Alaska Native Asian Pacific Islander

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Religion: Protestant Catholic Jewish Hindu Muslim Christian Jehovah Other:

Preferred Language

Occupation: Education: High School College Graduate Degree Other:

SS #

Spouse Name and DOB

1) With this consent, the office of My Ob/Gyn LLC may contact me as I indicate for purposes such as insurance items or anything pertaining to my clinical care, including laboratory results.

OK to contact me by any of the following methods

Home Phone

- OK to leave message with detailed information
Leave message with call-back information only
OK to leave limited info with family member

Cell Phone

- OK to leave message with detailed information
Leave message with call-back information only

Work Phone

- OK to leave message with detailed information
Leave message with call-back information only

OK to Mail, Email and / or Text (please circle)

2) Authorization for disclosure or obtaining your personal medical information

I authorize the disclosure of my medical information to: (I can revoke this authorization anytime)
relationship Auth Expires

EMERGENCY CONTACT INFORMATION. (Please list at least two)

Name Number Relationship
Name Number Relationship
Name Number Relationship

Signature of Patient or Legal Guardian

Date

Financial Policies and Notices Forms

Notice of Privacy Practices - Short Form

Page 1

Keep this form for your records. Acknowledgement of your receipt of this notice is located on the Authorizations and Notices page of the financial policy.

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice is complying with HIPAA's regulations.

What is HIPPA and how does the Privacy Rule affect you?

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996, this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information (IIHI)?

Any health information you provide our practice, including your demographic information. IIHI is any information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practice?

Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted in our waiting room and you can ask for a copy of the current notice at any time.

Treatment	Appointment Reminders	Release of Information to Family and Friends
Payment	Treatment Options	Disclosure Required by Law
Healthcare Operations	Health-related Benefits and Services	

The following categories describe unique situations in which we may use or disclose your identifiable health information:

Treatment	Health Oversight Activities	Lawsuits and Similar Proceedings	Law Enforcement
Payment	Organ & Tissue Donation	Serious Threats to Health or Safety	Research
Healthcare Operations	National Security Inmates	Workers' Compensation	

What are your rights concerning your Individually Identifiable Health Information (IIHI)?

You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below.

- | | |
|--------------------------------|---|
| 1. Confidential Communications | 5. Accounting of Disclosures |
| 2. Requesting Restrictions | 6. Right to a Paper Copy of This Notice |
| 3. Inspection and Copies | 7. Right to File a Complaint |
| 4. Amendment | 8. Right to Provide an Authorization for Other Uses and Disclosures |

To obtain more detailed information, request our 7 page full Privacy Policy from the front desk receptionist.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Privacy Officer for My Ob Gyn LLC 601 NW 179th Avenue, Suite 102 Pembroke Pines, FL 33029 (954) 436-2867 x4

Financial Policies and Notices Forms

Page 2

Financial Policy for My ObGyn, LLC

This page for patient reference

This financial policy contains important information regarding your financial responsibilities in return for medical services. These policies are important as we are committed to providing you with the best possible care while also controlling administrative costs. The individual receiving the service is the responsible party for all outstanding payments. In the case of a minor, the custodial parent(s) is considered the responsible party.

Patients with insurance:

Our practice participates with many health insurance companies; however, our relationship is with you and not your insurance company. Therefore, your responsibilities include:

- Keeping us updated with any type of insurance change
- Being prepared to pay your co-pay, coinsurance or deductible in full at the time services are rendered. What you pay in the office may or may not be the final total. Your final responsibility will be determined after your insurance company has reviewed the claim sent from our office.
- If you have a HMO that requires a referral for services, it is your responsibility to obtain this referral prior to your visit.
- For medical care that is not covered by your insurance, it is your personal responsibility to pay for services rendered in full at the time of service.
- For rejected claims and any claims not paid by your insurance, all charges will become the patient's responsibility and immediately due and payable.
- It is your responsibility to follow-up with your insurance company for any unpaid charges and secure payment in a timely manner. Payment is expected in full 60 days after we file with the insurance If your insurance does not pay within this time period, it will then be due and payable by you, the patient.

Patients without insurance or out-of-network insurance plan:

Full payment is due at the time of service unless other mutually agreed upon arrangements have been made with our billing staff.

Patients with Medicare/Medicaid:

We follow Medicare/Medicaid guidelines. If Medicare does not cover a service and you signed an "Advance Beneficiary Notice" for that service, you may be billed for the non-covered service.

Prompt payment statement:

Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly.

Payment Plans and Collections:

If you are having financial hardship and cannot pay your entire bill, we encourage you to contact our billing staff to discuss payment arrangements. We are here to help you.

If your account remains delinquent and we have not established payment options or you are delinquent with your payment plan or you have moved without giving us your forwarding information and your account is delinquent, please be aware that your account will be turned over to a collection agency and an additional fee will be added to your account balance.

Other fees:

\$32.00 Returned check fee

\$25.00 No-show fee

\$10.00 per page form completion fee not exceeding \$30.00

\$5.00 monthly charge for balances over 60 days old

\$50.00 charge for sending to collection company

We accept Checks/Cash, VISA®, MasterCard®, American Express® and Discover Card®

Financial Policies and Notices Forms

Patient Signature Page

Page 3

Name: _____ Date of Birth: _____

AGREEMENT TO PAYMENT POLICY

I acknowledge that I received a copy of *My Ob/Gyn, LLC* financial policy and agree to the terms of payment due.

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to *My Ob/Gyn, LLC*, any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to *My Ob/Gyn, LLC* for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT

I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to *My Ob/Gyn, LLC* are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices of *My Ob/Gyn, LLC*.

NOTICE OF MALPRACTICE INSURANCE

Dr. Helen Salisbury has elected not to carry Medical Malpractice Insurance which is permitted under Florida Law. However, Florida Law also stipulates that the uninsured doctor agree to satisfy adverse judgements 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 judgements arising from claims of medical malpractice.

Patient Signature

Date

Responsible Party

Relationship to Patient