Premier OB·GYN
Caring for Women with Experience and Dedication

Phone 321-397-1212 • Fax 321-397-1213
531 North Maitland Ave. Maitland, FL 32751

PATIENT INFORMATION - PLEASE PRINT

TODAY'S DATE

LAST NAME	FIRST NAME	M.I.	HOME PHONE	WORK PHONE
STREET ADDRESS			D.O.B.	CELL PHONE
CITY	STATE / ZIP	MARITAL STATUS S ☐ M ☐ W ☐ DIV. ☐ SEP. ☐	SOCIAL SECURITY #	
EMPLOYER NAME	ADDRESS		OCCUPATION	
REFERRED BY: ☐ YELLOW PAGES ☐ FRIEND ☐ OTHER	PRIMARY CARE PHYSICIAN	ETHNICITY / RACE	PREFERRED LANGUAGE	

SPOUSE / PARENT OR RESPONSIBLE PARTY

TODAY'S DATE

LAST NAME	FIRST NAME	M.I.	HOME PHONE	WORK PHONE
STREET ADDRESS			D.O.B.	SOCIAL SECURITY #
CITY	STATE / ZIP			
EMPLOYER NAME	ADDRESS		OCCUPATION	

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE COMPANY NAME	INSURANCE COMPANY NAME
ADDRESS / PHONE	ADDRESS / PHONE
CITY/STATE/ZIP	CITY/STATE/ZIP
I.D. NUMBER	I.D. NUMBER
GROUP NAME OR NUMBER / FIRST NAME	GROUP NAME OR NUMBER / FIRST NAME
INSURED'S LAST NAME	INSURED'S LAST NAME
DATE OF BIRTH / SOCIAL SECURITY #	DATE OF BIRTH / SOCIAL SECURITY #
RELATIONSHIP TO GUARANTOR ☐ SELF ☐ HUSBAND ☐ PARENT ☐ WIFE ☐ CHILD ☐ OTHER	RELATIONSHIP TO GUARANTOR ☐ SELF ☐ HUSBAND ☐ PARENT ☐ WIFE ☐ CHILD ☐ OTHER
EMPLOYER INS. PLAN YES ☐ NO ☐	EMPLOYER INS. PLAN YES ☐ NO ☐

EMERGENCY INFORMATION

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE
STREET ADDRESS	CITY/STATE/ZIP	OCCUPATION	

HOW WOULD YOU LIKE OUR OFFICE TO CONTACT YOU? PLEASE GIVE THREE PHONE NUMBERS.

1. _____ 2. _____ 3. _____

PAYMENT AGREEMENT & INFORMATION RELEASE

I understand it is my responsibility to provide correct insurance information for EACH date of service. I accept responsibility for any monies due if any of the information I have supplied is correct. I also understand that if for any reason my insurance will not cover this claim I will be held responsible for my bill. I give my consent to discharge any and all medical information necessary to process my insurance claim, I hereby authorize payment of insurance benefits to be paid directly to my treating physician or provider for service rendered. In the event of a collection or legal action, I will be responsible for any and all fees incurred.

_____
Patient/Responsible Party Signature Date

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Premier Obstetrics and Gynecology of Maitland, LLC is a HIPAA compliant office. Therefore, our staff is restricted by HIPAA rules and regulations in discussing the patient or the patient's medical information with only the patient, unless the patient has given us permission in writing to speak with someone else as well.

If you, the patient, wish for us to have the ability to discuss your file, including any medical information or financial information, please designate that individual(s) below and sign in the appropriate space.

In addition, on some occasions, we may try to contact you to discuss other issues, such as test results. We are also restricted as to what information we may leave on an answering machine. The law states that we can only leave our name and number and a request for you to call us back. If you would like us to leave more detailed information on your answering machine or voice mail, should you not be available to take our call, please designate in writing in the space provided below, exactly what information we are allowed to leave.

We appreciate you as our patient and your understanding of these complex issues.

I, (please print) _____, give permission to Premier Obstetrics and Gynecology of Maitland, LLC, to discuss my file, including medical and financial information, with the following individuals:

_____ Relationship : _____

_____ Relationship : _____

_____ Relationship : _____

I, (please print) _____, give permission to Premier Obstetrics and Gynecology of Maitland, LLC, to leave the following information on my answering machine or voice mail if I am not available at the time of their phone call:

_____

_____

_____

_____ _____

Patient's Signature Today's Date

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PATIENT HISTORY

Name: _____ Age: _____ Date:_____
Primary Care Physician: _____

PAST HEALTH HISTORY

Please list previous health problems:

_____
_____
_____
_____

Please list any prior surgeries and dates:

_____
_____
_____
_____

Please list medications, dosages, and any supplements you are taking

_____
_____
_____
_____

MEDICATION ALLERGIES

_____
_____
_____
_____
_____

Have you in the past, or are you currently taking any form of Hormone Replacement Therapy? ☐ Yes ☐ No
If yes, please list the type. This includes any herbal preparations: _____

OB/GYN HISTORY

Current contraception: ☐ Pill ☐ Tubal Ligation ☐ Condoms ☐ IUD ☐ Other:_____
Have you ever taken the pill? ☐ Yes ☐ No
Are you through having children and would you like to hear the options available for permanent birth control? ☐ Yes ☐ No
Are you sexually active? ☐ Yes ☐ No
Are your cycles regular? ☐ Yes ☐ No
Do you ever lose urine? ☐ Yes ☐ No
Number of vaginal deliveries: _____ C-Sections: _____ Miscarriages: _____ Abortions: _____
Date of last PAP smear: _____ Have you ever had an abnormal PAP smear? ☐ Yes ☐ No
Date of last mammogram: _____ Date of last menstrual cycle: _____
Date of last Bone Density Scan: _____

FAMILY HISTORY

Illness	Yes	No	Which Relative	Illness	Yes	No	Which Relative
Uterine Cancer	◯	◯		Stroke	◯	◯	
Ovarian Cancer	◯	◯		Heart Disease	◯	◯	
Endometriosis	◯	◯		Diabetes	◯	◯	
Breast Cancer	◯	◯		High Blood Pressure	◯	◯	
Colon Cancer	◯	◯					

SOCIAL HISTORY

Smoking: ☐ Yes ☐ No Packs/day: _____ Years: _____
Alcohol: ☐ Yes ☐ No Drinks/week: _____
Illegal Drug Use: ☐ Yes ☐ No What drugs: _____
Exercise: ☐ Yes ☐ No Which type: _____
History of spouse abuse ☐ Yes ☐ No
Are you a survivor of sexual abuse/assault: ☐ Yes ☐ No
Do you have any history of anorexia or bulimia: ☐ Yes ☐ No
Are you experiencing any lack of sexual libido? ☐ Yes ☐ No
Have you had more than 5 sexual partners? ☐ Yes ☐ No Are you sexually active with ☐ men ☐ women ☐ both
Have you had any feelings of sadness or depression on a regular basis? ☐ Yes ☐ No
Marital Status: ☐ Married ☐ Single ☐ Divorced
School Completed: ☐ High School ☐ College ☐ Graduate School
Current or most recent job: _____

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NAME: _____ DATE: _____

Please check boxes that apply for current or recent symptoms. Thank you very much.

Constitutional:
Weight loss ☐
Severe fatigue ☐

Eyes:
Double vision ☐
Vision changes ☐

Ears/Face/Mouth:
Sinus problems ☐
Sore throat ☐

Heart:
Chest pain ☐
Palpitations ☐
Painful breathing ☐

Lungs:
Wheezing ☐
Shortness of breath ☐

Intestinal:
Abdominal pain ☐
Frequent diarrhea ☐
Frequent vomiting ☐
Blood in stool ☐

Gynecologic:
Painful intercourse ☐
Irregular menses ☐
Very heavy menses ☐

Urinary System:
Loss of urine with coughing, laughing, or sneezing ☐
Frequent sense of urinary urgency ☐
Painful urination ☐
Blood in urine ☐

Musculoskeletal:
Muscle weakness ☐

Skin and Breast:
Skin rash ☐
Breast mass ☐
Nipple discharge ☐

Neurological:
Seizures ☐
Numbness ☐

Mental Health:
Depression ☐
Anorexia ☐
Bulimia ☐

Endocrine:
Abnormal thirst ☐
Hot flashes ☐

Blood system/Lymphatics:
Cuts will not stop bleeding ☐
Enlarged lymph nodes ☐
History of blood clots in legs ☐
Very easy bruising ☐

ALLERGY:
Drug allergies: NONE: ☐

Drug	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE CHECK THIS BOX IF YOU DO NOT HAVE ANY OF THE ABOVE SYMPTOMS: ☐

Date Reviewed: _____ _____ _____ _____ _____

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ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting us in writing.

You have the right to request that we restrict how protected heath information about you is used or disclosed for treatment, payment, or heath care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

_____
Patient Name (Print)

_____
Signature

_____
Date:

_____
Witness:

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OFFICE POLICIES

Welcome to Premier Obstetrics and Gynecology. We recognize that you have a choice when it comes to your heathcare, and we are honored that you chose us. We are a very busy practice, but we still want to give each patient individual attention. In an effort to keep this process as smooth and problem-free as possible, we must ask that the following policies be noted.

1. All clinically related calls go to our Nurse Triage line. You will be asked to leave your full name, birth date, and phone number along with your immediate problem on the Nurse's voicemail. The Nurse will return your call. This will allow her to have your chart in front of her when she is speaking with you. Please make sure you leave a number you can be reached at during daytime hours. Calls are returned in order of urgency, not necessarily in the order they are left. A patient who is experiencing a life-threatening situation will take precedence over all other calls. Please be assured that every effort will be made to return your call on the same day. Messages left after 4:00 in the afternoon will not be returned until the next business day. PLEASE DO NOT LEAVE A MESSAGE ON THE VOICEMAIL IF YOU ARE HAVING AN EMERGENCY.

2. Please allow 48-72 hours for prescription refills. Prescriptions will only be filled Monday - Thursday between 8:30 AM and 4:00 PM and on Fridays between 8:30 AM and 11:30 AM. Please have your pharmacy contact our office for refills. In order for prescription refills to be approved by our office you must have been seen within the year.
3. The refill of birth control pills or pain meds is not considered an emergency and will not be addressed on a weekend. If it looks like you might run out over a weekend, please plan accordingly and call our office before the weekend to allow us time to accommodate your requests/needs.

4. Please allow 7-10 days after lab tests and/or Ultrasound or X-Ray testing is completed before being notified of results, even over the phone.

5. The completion of disability forms and/or special request letters is time consuming and will take 7-10 days to complete. There is a $15.00 charge for the completion of these forms.

6. If we send you to another physician for consultation we will forward your records to that physician to ensure continuity of care. If, however, you want copies of your records for any other reason there is a nominal charge for these copies. The charge is $1.00 per page for the 1st 25 pages and 25¢ a page for each page after that. Please allow 7-10 days for this request.

7. Because we are a busy practice it is of the utmost importance that you keep all scheduled appointments. If you need to cancel or reschedule an appointment please allow us the courtesy of a 24-hour notice. With the exception of extreme circumstances, if you fail to give us 24 hours notice or if you do not show up for your appointment, you will be charged a fee of $50.00.

_____ _____

Patient's Signature Date

_____

Patient's Printed Name