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: _____ _____ _____ _____ _____