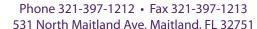


Patient/Responsible Party Signature

Date

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	MARITAL STATUS SOCIAL S			SECURITY	SECURITY #					
EMPLOYER NAME	ADDRESS						OCCU	PATION		
REFERRED BY: PRII					ETHNICITY RACE			PREFERRED LANGUAGE		
SPOUSE / PARENT OR RESPO	ONSIBLE PA	RTY			,		TODAY	O'S DATE		
LAST NAME FIRST NAME				M.I. HOME PI			PHONE	WORK PHONE		
STREET ADDRESS		D.O.B.			5	SOCIAL SECURITY #				
CITY				ZIP						
EMPLOYER NAME	ADDRESS						OCCU	PATION		
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	MBER FIRST NAME			GROUP NAME OR NUMBER				FIRST NAME		
INSURED'S LAST NAME				RED'S LAST NA	ME					
DATE OF BIRTH SOCIAL SECURITY #			DATE OF BIRTH SO			OCIAL SECU	CIAL SECURITY #			
RELATIONSHIP TO SELF HUSBAND GUARANTOR WIFE CHILD		PLOYER INS. PLAN		ANTOR -	SELF WIFE	☐HUSBAN	ID PARI	VES NO	LAN	
EMERGENCY INFORMATION										
NAME		RELATIONSHIP		HOME PHONE		WORK PHONE				
STREET ADDRESS			CITY/	STATE/ZIP		•	occ	UPATION		
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.										





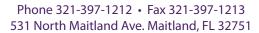
Premier Obstetrics and Gynecology of Maitland, LLC is a HIPAA compliant office. Therefore, our staff is restricted by HIPAA rules and regulations in discussing the patient or the patient's medical information with only the patient, unless the patient has given us permission in writing to speak with someone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





PATIENT HISTORY

Name:				Age:		Date	e:
Primary Care Physicia							
PAST HEALTH HISTORY Please list previous health problems:			Please list any prior surgeries and dates:				
Please list medication are taking	s, dosa	ges, an	d any supplements you	MEDICATION ALLERO	GIES		
			rently taking any form of des any herbal preparatio	Hormone Replacement	Therap	y? [
Are you sexually activ Are your cycles regula Do you ever lose urine Number of vaginal de Date of last PAP smea	he pill? ng child e? nr? e? liveries r:	dren an	d would you like to hear ☐ Yes ☐ No	the options available fo Miscarriages: _ d an abnormal PAP sme	r perma	anent /	birth control? Yes No
Date of last Bone Den							
FAMILY HISTORY							
Illness	Yes	No	Which Relative	Illness	Yes	No	Which Relative
Uterine Cancer	100	110		Stroke	1.00	1.10	
Ovarian Cancer				Heart Disease			
Endometriosis				Diabetes			
Breast Cancer				High Blood Pressure			
Colon Cancer							
Alcohol:	es 🗌 N	10 10	Drinks/week: What drugs:	Years:			
History of spouse abu Are you a survivor of s Do you have any histo Are you experiencing Have you had more th Have you had any feel Marital Status: School Completed:	se exual a ory of ar any lac an 5 se lings of	buse/a norexia k of sex xual pa sadnes Married High So	ssault:	 No No No No No Are you sexually ular basis? ☐ Yes ☐ Divorced ☐ Graduate School 		with	□ men □ women □ both





NAME:	DATI	E:
Please check boxes that apply for current or recent sym	ptoms. Thank you very much.	
Constitutional: Weight loss Severe fatigue	Musculoskeletal: Muscle weakness	
Eyes: Double vision Vision changes	Skin and Breast: Skin rash Breast mass Nipple discharge	
Ears/Face/Mouth: Sinus problems Sore throat	Neurological: Seizures Numbness	
Heart: Chest pain Palpitations Painful breathing	Mental Health: Depression Anorexia Bulimia	
Lungs: Wheezing Shortness of breath	Endocrine: Abnormal thirst Hot flashes	
Intestinal: Abdominal pain Frequent diarrhea Frequent vomiting Blood in stool	Blood system/Lymphatics: Cuts will not stop bleeding Enlarged lymph nodes History of blood clots in legs Very easy bruising	
Gynecologic: Painful intercourse Irregular menses Very heavy menses	ALLERGY: Drug allergies: Drug	NONE: Reaction
Urinary System: Loss of urine with coughing, laughing, or sneezing Frequent sense of urinary urgency Painful urination Blood in urine		
PLEASE CHECK THIS BOX IF YOU DO NOT HAVE ANY OF	THE ABOVE SYMPTOMS: \Box	
Date Reviewed:		