2345 W Hillsboro Blvd. ST#105
Deerfield Beach. FL, 33442
Phone: 954-427-4966
Fax: 954-427-6517

NAME____
(LAST) **(FIRST)** **(MI)**

ADDRESS________________________________**CITY**________________**STATE**______**ZIP**____________

HOME #_________________**CELL#**___________________**WORK#**___________________

EMAIL: _______________________________________

SS#_________________________ **DOB**_______________________ **AGE**_____________________

OCCUPATION_______________________________ **EMPLOYER**____________________________________

WORK ADDRESS:____

EMERGENCY CONTACT: NAME:________________________________ **PH #:**_________________________

PRIMARY CARE PHYSICIAN:________________________**PH#**_________________________

INSURANCE COMPANY:_______________________ **NAME OF INSURED:**____________________

POLICY #______________________ **GROUP#**_________________________

ALLERGIES:________________________ **MEDICATIONS:**____

SPECIAL DIET:____________________________________

SMOKE?____________**ALCOHOL?**______________**DRUG USE?**______________

HOW DID YOU HEAR ABOUT US?____

I ACKNOWLEDGE THAT I AM RECEIVING HEALTHCARE AT SOUTH FLORIDA WOMAN'S HEALTH ASSOCIATES/ HORMONE HEALTH LLC., AND I AGREE THAT I AM PERSONALLY RESPONSIBLE FOR THESE CHARGES REGARDLESS OF MY INSURANCE STATUS. SHOULD THESE CHARGES BECOME DELINQUENT, INTEREST MAY INCUR AT THE CURRENT MONTHLY RATE. I WILL BE RESPONSIBLE FOR ALL COSTS OF COLLECTIONS INCLUDING COURT COSTS, ATTORNEYS FEES AND INTEREST. I HEREBY AUTHORIZE THE RELEASE OF MY COMPLETE MEDICAL RECORDS WHEN NECESSARY TO AUTHORIZED PHYSICIANS,HOSPITALS,MEDICAL ATTENDANTS,ATTOURNEYS AND INSURANCE COMPANIES. I ASSIGN MEDICAL INSURANCE BENEFITS TO SOUTH FLORIDA WOMANS HEALTH ASSOCIATES/ HORMONE HEALTH LLC. OR ITS ASSIGNEES. IF THERE IS A UNCOVERED INSURANCE ITEM I WILL BE RESPONSIBLE FOR PAYMENT. I UNDERSTAND THAT BY PROVIDING MY EMAIL ADDRESS, I WILL BE SENT CORRESPONDENCE IN AN ELECTRONIC FASHION FROM THE MEDICAL GROUP.

___________________________ ______________________________ ____________________________
PATIENT SIGNATURE **EMPLOYEE INITAL** **DATE**

SELF MEDICAL HISTORY

NAME:____

REASON FOR VISIT:____

TOTAL # OF PREGNANCIES:____________# OF FULL TERM DELIVERIES:__________

#MISCARRIAGES:_________#ABORTIONS:_______#LIVING CHILDREN:___________

CHECK ALL THAT APPLY.

PAST MEDICAL HISTORY

HEART DISEASE______DIABETES_______HEADACHES________

PELVIC INFECTIONS_______BREAST LUMPS_____DEPRESSION_____

THYROID PROBLEMS_____BLADDER PROBLEMS_____ANEMIA_____

HIGH BLOOD PRESSURE_____HERPES_____ABNORMAL PAP_____

GENTIAL WARTS_____FIBROIDS_____CANCER_____SEIZURES_____

SURGERIES____

CURRENT REVIEW OF SYMPTOMS

HEADACHES_____BLURRED VISION_____FEVER_____DIZZINESS_____

HOT FLASHES_____INSOMNIA_____LOW SEX DRIVE_____VAGINAL DRYNESS_____

PELVIC PAIN_____URINARY PROBLEMS_____EXCESSIVE VAGINAL BLEEDING_____

BREAST PAIN_____BREAST LUMP_____DIZZINESS_____ANXIETY_____

FAMILY HISTORY

HEART DISEASE_____CANCER_____TYPE?______________________

DIABETES_____HIGH BLOOD PRESSURE______OBESITY_____STROKE_____

EARLY MENOPAUSE_____GENETIC ABNORMALITIES_____

Acknowledgment of Notice of Privacy Practices

____

NAME OF PATIENT (PRINT PLEASE)

____

DATE OF BIRTH

I HEARBY ACKNOWLEDGE THAT I RECEIVED SFWHA/ HORMONE HEALTH LLC'S NOTICE OF PRIVACY PRACTICES.

______________________________ ______________________

SIGNATURE OF PATIENT **DATE**

____

WITNESS

I____________________________ am authorizing SFWHA/Hormone Health to release medical information in case that I am not able to be reached to the following:

NAME	DOB	RELATIONSHIP TO PATIENT
1.________________	______________	________________________
2.________________	_______________	________________________
3.________________	______________	________________________

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another patient who is waiting for an appointment to be schedules in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other patients

Office appointments which are cancelled with less than **24 hours notification** may be subject to a **$50.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as a **NO SHOW.** Patients who No-show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to a **$50.00 fee for office appointment no show.**

The cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patients next appointment.

We understand the special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship's are based upon understanding and good communication. Questions about cancellation and No Show Fees should be directed to the Billing Department.

Please sign that you have read, understand and agree to this cancellation and No Show Policy.

__________________________ ________________

Patient Name (Please Print) Date of Birth

__________________________ ________________

Patient Signature Date