A New Life

OB/GYN of Broward

Experienced, Compassionate Care.

Jane E. Matos-Fraebel, M.D., F.A.C.O.G.

NAME: _____ AGE: _____ DATE OF BIRTH: ____/____/_____

LAST 4 DIGITS OF SOCIAL SECURITY# _____ HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DRIVER'S LICENSE# _____ STATE OF ISSUE: _____ EXPIRATION DATE: ____/____/_____

CELLPHONE: ( ) _____-_____ HOME: ( ) _____-_____ WORK: ( ) _____-_____

WHAT IS THE BEST NUMBER TO CONTACT YOU BETWEEN 9 AM & 5 PM? (CIRCLE ONE) CELLPHONE HOME PHONE WORK PHONE

EMAIL: _____@_____. _____ OCCUPATION: _____ EMPLOYER: _____

WORK ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

ARE YOU MARRIED? Y N IF YES, SPOUSE'S NAME: _____

IF NO, PLEASE CIRCLE ONE: SINGLE WIDOWED DIVORCED DOMESTIC PARTNER OTHER: _____

IN CASE OF AN EMERGENCY, WHO SHOULD WE CONTACT?

_____ RELATIONSHIP TO YOU? _____ Phone: ( ) _____-_____

_____ RELATIONSHIP TO YOU? _____ Phone: ( ) _____-_____

WHAT IS THE REASON FOR YOUR VISIT? _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO IF YES, WHICH ONES? _____

HOW DID YOU HEAR ABOUT US/WHO REFERRED YOU? _____ WHO IS YOUR PRIMARY CARE DOCTOR? _____

IN AN EMERGENCY, WILL YOU ACCEPT BLOOD PRODUCTS TO SAVE YOUR LIFE? YES NO

WHO IS YOUR PRIMARY INSURANCE CARRIER? _____ POLICY # _____

GROUP # _____ NAME OF INSURED: _____

DATE OF BIRTH OF INSURED: _____/_____/_____ RELATIONSHIP TO INSURED: _____

WHO IS YOUR SECONDARY INSURANCE CARRIER? _____ POLICY # _____

GROUP # _____ NAME OF INSURED: _____

DATE OF BIRTH OF INSURED: _____/_____/_____ RELATIONSHIP TO INSURED: _____

WHAT WAS THE DATE OF YOUR LAST GYN ANNUAL WELLNESS VISIT? ____/_____/_____ DATE OF LAST PAP SMEAR? _____/_____/_____

HIPAA PRIVACY NOTICE RECORD: I HAVE RECEIVED THE PRIVACY NOTICE OF HEALTH INFORMATION PRACTICES (The Health Insurance Portability and Accountability Act)

SIGNATURE: _____ **DATE:** _____/_____/_____

I _____ UNDERSTAND I AM RESPONSIBLE FOR THE CORRECTNESS AND TRUTHFULNESS OF THE INFORMATION CONTAINED ABOVE. I AM HEREBY ADVISED THAT ANY FALSE OR WRONG INFORMATION SUBMITTED ON THIS FORM IS FRAUDULENT AND WILL CAUSE ME TO BE RESPONSIBLE FOR MY TOTAL BILL IN FULL. **ALL CO-PAYMENTS AND DEDUCTIBLES ARE DUE AND PAYABLE AT TIME OF SERVICE.** THE UNDERSIGNED AKNOWLEDGES AND AGREES THAT THE PRIMARY RESPONSIBILITY FOR ANY CHARGES RENDERED FOR MEDICAL SERVICES RELATIVE TO MY CARE BY A NEW LIFE OB/GYN OF BROWARD, LLC AND JANE E MATOS-FRAEBEL, MD FACOG IS THE PRIMARY RESPONSIBILITY OF THE UNDERSIGNED, AND NOT OF ANY PUBLIC OR PRIVATE INSURANCE COMPANY OR AGENCY, OR THE ATTORNEYS OF THE UNDERSIGNED. IT IS FURTHER SPECIFICALLY UNDERSTOOD AND AGREED THAT IF COLLECTION PROCEDURES MUST BE INSTITUTED RELATIVE TO ANY CHARGES MADE HEREUNDER, THE UNDERSIGNED WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS INCLUDING REASONABLE ATTORNEY FEES IN ADDITION TO THE AMOUNT OWED FOR MEDICAL SERVICES.

SIGNATURE: _____ **DATE** _____/_____/_____