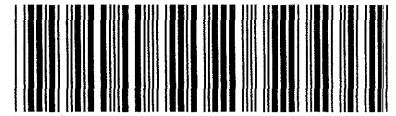


**Obstetrics & Gynecology Associates, P.A.**

specializing in  
*Obstetrics, Gynecology, Infertility  
and Laser Surgery*



**REGISTRATION SLIP**

Date \_\_\_\_\_

NAME \_\_\_\_\_  
(last) (first) (middle)

ADDRESS \_\_\_\_\_ Apt#: \_\_\_\_\_  
(city) (state) (zip code)

TELEPHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

CELL PHONE # \_\_\_\_\_

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ SS# \_\_\_\_\_

D.O.B. \_\_\_\_\_ SPOUSE PHONE# \_\_\_\_\_

PARENT'S NAME IF MINOR \_\_\_\_\_

PATIENT'S OCCUPATION \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_

(telephone) (ext.)

**MEDICAL INSURANCE**

PRIMARY: Name of Company \_\_\_\_\_ Insured's Name \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_

SECONDARY: Name of Company \_\_\_\_\_ Insured's Name \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**RELATIVE NOT LIVING IN YOUR HOME WHOM WE MAY CONTACT IN CASE OF EMERGENCY**

NAME \_\_\_\_\_ PHONE # \_\_\_\_\_  
(last) (first) (middle)

**Financial Agreement and Authorization for Treatment:**

I authorize treatment of the person named above and agree to pay all fees charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentation thereof, unless prior arrangements have been made in writing prior to billing date.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereof, and proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for collection

**ASSIGNMENT OF BENEFITS**

I hereby authorize Obstetrics and Gynecology Associates, P.A., to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such surgical or medical care. I also authorize and request my insurance company to pay directly to the above named Doctors the amount due me in my claim for basic medical, major medical and/or surgical treatment or services, by reason of such treatment or services rendered to:

I agree that Obstetrics and Gynecology Associates, P.A. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

\_\_\_\_\_  
(Please print name)

\_\_\_\_\_  
(Signature)

## **Medical Malpractice Insurance**

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

### **OUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE**

This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

#### **Florida Statute 458.320(5)(g)(1)**

I, \_\_\_\_\_, have received and read the above statements.

Signature: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Date: \_\_\_\_\_

## Consent:

1. I, \_\_\_\_\_, give permission for the person(s) listed below, to accompany me in the exam room, to pick up **any** medical records on my behalf, and to speak with any employee over the telephone, **with the full knowledge that any and all past and present medical history may be divulged.**

\_\_\_\_\_ - **Accept (If you checked Accept, please fill in names below)**  
\_\_\_\_\_ - **Decline**

\_\_\_\_\_  
Last name, First name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Last name, First name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Last name, First name

\_\_\_\_\_  
Relationship

2. I understand that my provider at Obstetrics and Gynecology Associates P.A. may order additional request (Example: Blood work, ultrasound, mammogram, etc.) and it is my full responsibility to check with my insurance regarding coverage prior to having test perform. Obstetrics and Gynecology Associates, P.A. is not responsible for any non covered request.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## Urinary Health Survey:

1. Do you ever leak urine when you cough, laugh, or sneeze? \_\_\_\_\_ Yes \_\_\_\_\_ No
2. Do you ever feel as though you have to urinate urgently? \_\_\_\_\_ Yes \_\_\_\_\_ No
3. Do you feel like you have to urinate to frequently? \_\_\_\_\_ Yes \_\_\_\_\_ No