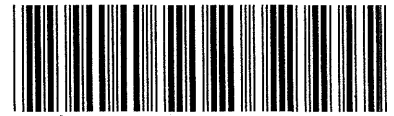


Obstetrics & Gynecology Associates, P.A.

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

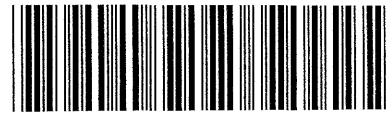
Date

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



Name:

DOB:

Date:

Obstetrics & Gynecology Associates, P.A.
2400 North Orange Blossom Trail, Suite 300
Kissimmee, FL 34744
407-846-7200
Fax: 407-846-3989

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

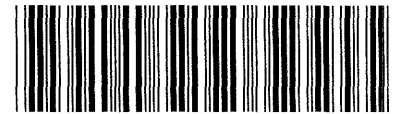
Dated: _____

Patient or Patient's Representative: _____

Print Patient's Name: _____

If signed by Representative, state name of Representative: _____

Relationship to Patient: _____



GYNECOLOGIC INTAKE HISTORY

NAME: _____ BIRTHDATE: _____ DATE: _____
 ADDRESS: _____
 HOME TEL: _____ WORK TEL: _____
 EMPLOYER: _____ INSURANCE: _____
 NAME OF SPOUSE/PARTNER: _____

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN

	Currently	Past	Notes
1. Constitutional Weight loss Weight gain Fever Fatigue	_____ _____ _____ _____	_____ _____ _____ _____	
2. Eyes Double vision Spots before eyes Vision changes	_____ _____ _____	_____ _____ _____	
3. ENT/Mouth Ear aches Ringing in ears Sinus problems Sore throat Mouth sores Dental problems	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	
4. Cardiovascular Painful breathing Chest pain Difficulty breathing on exertion Swelling of legs Palpitations of heart	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	
5. Respiratory Wheezing Spitting up blood Shortness of breath Cough, chronic	_____ _____ _____ _____	_____ _____ _____ _____	
6. Gastrointestinal Diarrhea, frequent Bloody stool Nausea / vomiting Constipation	_____ _____ _____ _____	_____ _____ _____ _____	
7. Genitourinary Blood in urine Pain in urination Urgency Frequency of urination Incomplete emptying Stress incontinence Abnormal periods Painful intercourse	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____	
8. Musculoskeletal Muscle weakness	_____	_____	
9. Skin / breast Pain in breast Discharge Masses Rash Ulcers	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	

NAME:

DOB:

DATE:



REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
	Currently	Past	Notes
10. Neurological			
Dizziness	_____	_____	
Seizures	_____	_____	
Numbness	_____	_____	
Trouble waling	_____	_____	
11. Psychiatric			
Depression	_____	_____	
Crying, frequent	_____	_____	
12. Endocrine			
Dry skin	_____	_____	
Abnormal thirst	_____	_____	
Hot flashes	_____	_____	
13. Hematologic / Lymphatic			
Bruises, frequent	_____	_____	
Cuts do not stop bleeding	_____	_____	
Enlarged lymph nodes	_____	_____	
14. Allergic / Immunologic			
Allergies	_____	_____	
Drugs, other	_____	_____	

PERSONAL PAST HISTORY

MAJOR ILLNESSES	Yes	No	MAJOR ILLNESSES	Yes	No
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression / anxiety		
Kidney Infections / stones			Anemia / Blood transfusions		
Tuberculosis			Seizures / convulsions / epilepsy		
Venereal Disease			Bowel Trouble		
Heart Trouble / murmur			Glaucoma		
Diabetes			Arthritis / joint pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis / Yellow jaundice		
Rheumatic Fever			Thyroid Disease		

OPERATIONS / HOSPITALIZATIONS

Reason	Date	Reason	Date

INJURIES / ILLNESSES

Reason	Date	Type	Date

LAST IMMUNIZATION OR TEST

	Date		Date
Tetanus		Pneumonia	
Flu Shot		TB Skin Test	

OB / GYN HISTORY

	Number		Number
Births		Abortions	
Miscarriages		Living Children	

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

