## OB/GYN WOMENS CENTRE OF LAKEWOOD RANCH, LLC
## REGISTRATION FORM

(Barcode)

(PLEASE PRINT)

| | | | |
|---|---|---|---|
| **Patient Name(Last, First, MI)** | | | |
| **Birth date: / /** | **Age:** | **Marital status (circle one)** | **Single / Married / Divorced / Separated / Widow** |
| **Street Address:** | | **Email Address:** | |
| **City:** | **State:** | **ZIP Code:** | **SS#:** |
| **Cell Phone:** | **Home Phone:** | **Work Phone:** | |
| **Occupation:** | **Employer:** | | |
| ***Reason for appointment*** | ***(please circle)*** **Yearly Gyn Problem Consult** | **Date of last yearly exam: / /** | |

### INSURANCE INFORMATION

**(Please give your insurance card and photo identification to the receptionist.)**

| | | |
|---|---|---|
| **Please indicate primary insurance:** | | |
| **Insurance ID#:** | **Group #:** | **Co-pay: $** |
| **Subscriber's name:** | | **Subscriber's Birth date: / /** |
| **Patient's relationship to subscriber:** ❑ **Self** ❑ **Spouse** ❑ **Child** ❑ **Domestic Partner** | | |
| **Name of secondary insurance:** | **Subscriber's name:** | |
| **Group #:** | **Policy #:** | |

### IN CASE OF EMERGENCY

| | | |
|---|---|---|
| **Name of local friend or relative:** | | |
| **Home phone #:** | **Cell phone #:** | **Relationship:** |

### AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

| | |
|---|---|
| **Preferred Pharmacy Name** | **Primary Care Physician:** |
| **Location:** | **Address:** |
| **Phone:** | **Phone:** |
| **May we call you at home? Yes No** | **May we send a yearly recall to your home? Yes No** |
| **May we leave a message at your home? Yes No** | **May we call you at work? Yes No** |
| **May we leave a message on your cell? Yes No** | **May we obtain your Medication History? Yes No** |

**Contact Preference: (please circle one) Home Cell Work**

**Health Communication Preferences: (please circle)**

**Health Notifications: Email Phone Pt Portal Text Announcements: Email Phone Pt Portal Text**

**Appointments: Email Phone Pt Portal Text Billing: Email Phone Pt Portal Text**

**You may release or disclose information to the following:**

| | | |
|---|---|---|
| **Name:** | **Relationship:** | **Phone:** |
| **Name:** | **Relationship:** | **Phone:** |

**PLEASE CONTINUE TO NEXT PAGE**

**I acknowledge and agree to adhere to the Notice of Privacy Practices as required by federal and state guidelines. I understand I may request and review a copy of these Practices at any time from the office staff. I permit the release of my pharmacy information and the release of any information, including my medical records, that may be requested by my insurance company to process any claims or as I have indicated above. I authorize the use of this signature on all insurance submissions, whether manual or electronic.**

| ***Patient/Guardian signature*** | ***Date*** |
|---|---|

## CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

**I have completed this form and certify that I am the patient or duly authorized agent of the patient. I authorize the providers of Ob/Gyn Women's Centre of Lakewood Ranch, LLC to provide medical care and treatment for me.**

**I hereby authorize payment of benefits to be made directly to Ob/Gyn Women's Centre of Lakewood Ranch, LCC and/or any of the providers individually. I understand, as the recipient of services, regardless of insurance coverage, that I am ultimately responsible for payment within 30 days of the date of service. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, whether manual or electronic.**

| ***Patient/Guardian signature*** | ***Date*** |
|---|---|
| ***Printed Name:*** | ***Relationship:*** |

Dear Patients,

Our medical providers are participating in a government program that encourages the adoption of electronic health records. This technology is supposed to lead to reduced health care costs but it will also improve the quality of your care and our ability to communicate with you, our patients. As part of this program, the government requires us to record the following demographic information about you:

u Preferred language u Race u Ethnicity u

The U.S. Centers for Disease Control and Prevention (CDC) provides the options for the race and ethnicity fields that match the data collection standards defined by the U.S. Office of Management and Budget (OMB) and the U.S. Bureau of the Census (BC). We maintain secure records and assure you that this information will remain confidential. You can help us by reviewing the list of options below and providing your race and ethnicity information during registration or check-in. If you do not wish to provide this information, you may simply decline.

Thank you for your assistance!

Please identify your Race from the following CDC-defined options:

| | | | |
|---|---|---|---|
| ☐ African | ☐ African American | ☐ Alaska Native | ☐ American Indian |
| ☐ American Indian or Alaska Native | | ☐ Arab | ☐ Asian |
| ☐ Asian Indian | ☐ Bahamian | ☐ Bangladeshi | ☐ Barbadian |
| ☐ Bhutanese | ☐ Black | ☐ Black or African American | ☐ Burmese |
| ☐ Cambodian | ☐ Chinese | ☐ Dominica Islander | ☐ Dominican |
| ☐ European | ☐ Filipino | ☐ Haitian | ☐ Hmong |
| ☐ Indonesian | ☐ Iwo Jiman | ☐ Jamaican | ☐ Japanese |
| ☐ Korean | ☐ Laotian | ☐ Madagascar | ☐ Malaysian |
| ☐ Maldivian/N African | ☐ Melanesian | ☐ Micronesian | ☐ Middle Eastern |
| ☐ Native Hawaiian or Other Pacific Islander | | ☐ Nepalese | ☐ Okinawan |
| ☐ Other Race | ☐ Pakistani | ☐ Polynesian | ☐ Singaporean |
| ☐ Sri Lankan | ☐ Taiwanese | ☐ Thai | ☐ Tobagoan |
| ☐ Trinidadian | ☐ Vietnamese | ☐ West Indian | ☐ White/Caucasion |

Please identify your Ethnicity from the following CDC-defined options:

| | | | |
|---|---|---|---|
| ☐ Central American | ☐ Cuban | ☐ Dominican | ☐ Hispanic or Latino/Spanish |
| ☐ Latin American | ☐ Mexican | ☐ Not Hispanic or Latino | ☐ Puerto Rican |
| ☐ South American | ☐ Spaniard | | |

(Barcode)

**OB/GYN Women's Centre of Lakewood Ranch, LLC**
**HEALTH QUESTIONNAIRE**
(Please Print) **(Barcode)**

| **Today's date:** | | |
|---|---|---|
| **Patient's last name:** | **First name:** | **MI:** |
| **Age:** | **Date of Birth:** | **Primary Physician:** |
| **Reason for your visit today:** | | |

| **Allergies (***Medications, Latex, Iodine***...):** | **Reaction (***Rash, Hives, Anaphylaxis...***):** | **Severity (***Severe, Mild…***):** |
|---|---|---|
| | | |
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| | | |
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| **Current Prescribed Medications:** | **Name:** **Strength:** **Directions:** |
|---|---|
| **Name:** **Strength:** **Directions:** | |
| | |
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## GYNECOLOGICAL HISTORY

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|---|---|
| **Date of Last Menstrual Period?** | **How often do your menstrual periods occur?** |
| **Is the Flow: Light Moderate Heavy Cramping Y/N** | **How many days do your menstrual periods last?** |
| **If postmenopausal age at Menopause:** | **At what Age did you begin menstruation?** |
| **Current Birth Control method:** | **HPV Vaccination Series Completed? Yes No If Yes when?** |
| **Do you have any history of Sexually Transmitted Diseases? Yes No If yes, which:** | |
| **Date of Last Pap and result:** | **Date of Last Mammogram and result:** |
| **History of Abnormal Pap Smear:** | **History of Abnormal Mammograms:** |
| **Date of Last Colonoscopy:** | **History of Breast Problems? Yes No** |
| **Are you sexually active? Yes No** | **Sexual Orientation: Hetero / Homo/ Bi sexual** |
| **Total Life time Partners? NONE Less than 5 More than 5** | **Date of Last Bone Density (Dexa):** |
| **Age at first sexual experience:** | **History of Endometriosis /Fibroids /Infertility/ Ovarian Problems?** |

## OBSTETRICAL HISTORY

| | |
|---|---|
| **How many times have you been pregnant?** | **How many children do you have?** |
| **Any miscarriages? Yes No How Many?** | **Any abortions? Yes No How Many?** |
| **Any Ectopic Pregnancies? Yes No How Many?** | **Any Premature Deliveries? Yes No How Many?** |

**Pregnancy History:**

| **DOB:** | **#of Fetus** | **Full or PreTerm/ Gestational Weeks** | **Length of Labor (hours)** | **Birth Weight lbs/oz** | **Sex** | **Delivery Type** | **Anesthesia** | **Complications** |
|---|---|---|---|---|---|---|---|---|
| / / | | / | | / | | | | |
| / / | | / | | / | | | | |
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| / / | | / | | / | | | | |
| / / | | / | | / | | | | |
| / / | | / | | / | | | | |

| PAST MEDICAL HISTORY (please circle) | | |
|---|---|---|
| Cancer-BRCA Tested | GI-Colon Polyps | Ortho-Other |
| Cancer-Breast | GI-Crohn's/Ulcerative Colitis | Psych-ADD |
| Cancer-Cervical | GI-Gallbladder Disease | Psych-Anxiety Disorder |
| Cancer-Colon | GI-Hemorrhoids | Psych-Bipolar Disease |
| Cancer-Endometrial/Uterine | GI-Irritable Bowel Syndrome | Psych-Depression |
| Cancer-Lung | GI-Liver Disease/Hepatitis | Psych-Eating Disorder |
| Cancer-Other | GI-Other | Psych-Other |
| Cancer-Ovary | GI-Reflux/Stomach Ulcers | Psych-PMS/PMDD |
| Cancer-Skin/Melanoma | GI-Vitamin Deficiency | Pulmonary-Asthma |
| Cancer-Vaginal | Hematology-Anemia | Pulmonary-COPD/Emphysema |
| Cancer-Vulvar | Hematology-Bleeding Disorder | Pulmonary-Other |
| Cardiac-Heart Arrhythmia | Hematology-Blood Clotting Disorder/Factor 5 Leiden | Pulmonary-Seasonal Allergies |
| Cardiac-Heart Disease | Hematology-Blood Transfusion | Pulmonary-Sleep Apnea |
| Cardiac-High Blood Pressure | Hematology-DVT/Pulmonary Embolism | Rheumatology-Arthritis |
| Cardiac-High Cholesterol | Hematology-Other | Rheumatology-Autoimmune Disease |
| Cardiac-Other | ID-Shingles | Rheumatology-Fibromyalgia/Chronic Pain |
| Dermatology-Acne | ID-HIV | Rheumatology-Other |
| Dermatology-Eczema/Psoriasis | ID-MRSA | Rheumatology-Restless Leg Syndrome |
| Dermatology-Other | ID-Other | Urology-Frequent UTI |
| ENT-Hearing Loss | ID-Rheumatic Fever | Urology-Hematuria (blood in urine) |
| ENT-Other | ID-Tuberculosis/Positive PPD | Urology-Interstitial Cystitis |
| Endocrinology-Diabetes/History of Gestational Diabetes | ID-Usual Childhood diseases-Chicken Pox | Urology-Kidney Disease |
| Endocrinology-Elevated Prolactin | Neurology-Headaches/Migraines | Urology-Kidney Infection |
| Endocrinology-Osteopenia | Neurology-Memory Loss/Dementia | Urology- Other |
| Endocrinology-Osteoporosis | Neurology-Neuropathy | Urology-Urinary Incontinence |
| Endocrinology-Other | Neurology-Other | Urology-Kidney Stones |
| Endocrinology-Thyroid Problems Hypo/Hyper/Other | Neurology-Seizures/Epilepsy | Wt Management-Obesity |
| Eyes-Cataracts | Neurology-Stroke/TIA | Wt Management-Other |
| Eyes-Glaucoma | Ortho-Chronic Back Pain | |
| Eyes-Other | Ortho-Degenerative Joint Disease | |
| Eyes-Vision Loss/Macular Degeneration | Ortho-Fractures | |

| GENERAL MEDICAL HISTORY/REVIEW OF SYSTEMS | | |
|---|---|---|
| Occupation: | Highest Level of Education: | |
| Exercise Level: Low Med High | Diet: Regular / Vegetarian / Other: | Wear seatbelt Routinely? Yes / No |
| Marital Status: Single / Mar / Divorced / Sep / Widowed | Any history of Domestic Violence? Yes / No | |
| Smoking Status: Never / Former / Current / Occasional | How much per day? How many years? | |
| Alcohol Intake: None / Occasional / Moderate / Heavy | If applicable: Use Pre-Pregnancy? Yes / No | |
| Caffeine Intake: None / Occasional / Moderate / Heavy | If applicable: Use Pre-Pregnancy? Yes / No | |
| Illegal Substance: None / Occasional / Moderate / Heavy | If applicable: Use Pre-Pregnancy? Yes / No | |
| Is a blood transfusion acceptable in the event of an emergency? Yes / No | | |

| FAMILY HISTORY | | | | |
|---|---|---|---|---|
| | **Age** | **If Living-please list serious medical conditions & onset Age** | **Age at Death** | **Cause of Death** |
| **Father** | | | | |
| **Mother** | | | | |
| **Brother** | | | | |
| **Sister** | | | | |
| **Maternal Grandmother** | | | | |
| **Maternal Grandfather** | | | | |
| **Maternal Aunt** | | | | |
| **Maternal Uncle** | | | | |
| **Paternal Grandmother** | | | | |
| **Paternal Grandfather** | | | | |
| **Paternal Aunt** | | | | |
| **Paternal Uncle** | | | | |

| SURGICAL HISTORY | | |
|---|---|---|
| **Date:** | **Type:** | **Physician:** |
| **Date:** | **Type:** | **Physician:** |
| **Date:** | **Type:** | **Physician:** |
| **Date:** | **Type:** | **Physician:** |
| **Date:** | **Type:** | **Physician:** |
| **Date:** | **Type:** | **Physician:** |
| **Date:** | **Type:** | **Physician:** |

| VACCINE HISTORY | |
|---|---|
| **Date:** | **Type:** |
| **Date:** | **Type:** |
| **Date:** | **Type:** |
| **Date:** | **Type:** |

**To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect or incomplete information can be dangerous to my health. I acknowledge and agree it is my responsibility to inform Ob/Gyn Women's Centre of Lakewood Ranch, LLC of any changes in my medical status prior to receiving medical treatment. I also authorize the healthcare staff to perform and order any necessary services I may need.**

| | |
|---|---|
| ***Patient/Guardian signature*** | ***Date*** |