ObGyn Associates

Kelly Jago, MD | Laila Needham, MD | Eric Pulsfus, MD | Thomas Searle, MD | Karen Toppi, MD | Susan Yarian, MD
Elizabeth Arnett, CNM | Barbara Dembek, CNM | Amy Loughlin, CNM | Elizabeth Meadows, CNM | Michele Rogero, CNM | Lisa Salt, PA-C
300 Health Park Blvd., Ste. 3002, St. Augustine, FL 32086 | phone.904.819.1500 | fax.904.810.1023

Patient Registration and Insurance Information

Name: _____ D.O.B. _____/_____/_____ SS# _____-_____-_____
Address: _____
City: _____ State:_____ Zip: _____
Home Phone: _____ Cell Phone: _____ Consent to Text: Y/N
Work Phone: _____ext:_____
Email Address:_____ ☐decline to report

Marital Status: ☐ married ☐ domestic partner ☐ single ☐ divorced ☐ separated ☐ widowed ☐ unknown

How do you prefer to be contacted? ☐Home phone ☐Cell phone ☐Patient Portal ☐standard mail

In which language do you communicate? _____
In case of an EMERGENCY we have permission to contact Name:_____
Number: _____

We are required by law to ask which RACE and what ETHNICITY best describes you (you may decline to report). Please choose one in each of the following categories

RACE:
☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Pacific Islander
☐White
☐Other _____
☐Decline to report

ETHNICITY
☐Hispanic or Latina
☐Not Hispanic or Latina
☐ Other _____
☐ Decline to report

PLEASE COMPLETE ALL INSURANCE INFORMATION

If you do NOT have insurance, check here _____

Insurance Co._____ Name of insured_____

Policy holder's date of birth:_____ Relationship _____

Primary Pharmacy: _____ Primary Lab(circle one) LABCORP/QUEST/Other

Primary Imaging Facility:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical or medical benefits to OBGYN ASSOCIATES for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize OBGYN ASSOCIATES to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I understand I may revoke this consent at any time by notifying OBGYN ASSOCIATES in writing. OBGYN ASSOCIATES has the right to refuse treatment should I revoke or refuse this consent.

Patient Signature _____ Date _____

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Privacy Issues for Patients

I have read and understand the "Notice of Privacy Practices" which is available at the front desk. A printed copy is available upon request.

Signature: _____ Date: _____

Please list the following people that you give OB/GYN ASSOC. OF ST. AUGUSTINE permission to release your detailed medical information to. IF you choose not to release your medical information, please write NONE below.

(Please print)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Office Policies

1. Your co-pay is due at the time of service. You are responsible for any deductible insurance amounts.

2. If your insurance requires a referral or authorization, it is your responsibility to get it.

3. Your insurance company has contracted with a lab for any blood work, PAP smears or biopsies. You should know which lab to visit for blood work. We will make every attempt to send any specimens to the correct lab. Our office does not bill for lab work; the lab company will bill you for any labs, PAP smears or biopsies.

4. Our office has a $50.00 NO SHOW fee and requires a 24 hour notice of any cancellations.

Signature: _____ Date: _____

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WELCOME TO OUR PRACTICE! 4/3/17

Name:_____ DOB : _____ Date:_____

How can we help you today? Check-up _____ Problem ____ (Briefly describe. If you would prefer to leave this blank, that's fine) _____

Are you allergic to any medications?

_____

_____

Current medications (Please include birth control and herbal supplements

_____

_____

_____

Who is your primary care provider?

_____

What is your primary pharmacy?

_____

GYNECOLOGIC HISTORY

Date of last menstrual period ____/____/_____

Date of last mammogram ___/___/___ Date of last colonoscopy ___/___/___ Date of last bone density ___/___/__

Date of last Pap smear ____/____/_____ Abnormal Pap ☐Y ☐N If yes, when? ____/____/_____

Have you received the HPV vaccine? ☐Y ☐N If yes, was the three shot series completed? ☐Y ☐N

Are you interested in receiving information on the HPV vaccine for you or a family member? ☐Y ☐N

Do you identify as ☐Heterosexual ☐Homosexual ☐Bisexual ☐Transgender Are you sexually active?☐Y ☐N

How long have you been with your partner? _____

Are you currently using a birth control method? ☐Y ☐N Type: _____

Do you have any history of sexually transmitted diseases? ☐Y ☐N _____

Age at onset of period _____ If menopausal, age at time of last period_____

Any significant GYN history? _____

_____

OBSTETRIC HISTORY

How many pregnancies have you had total (including miscarriages)? _____How many deliveries? _____

Delivery History:

	Date of Birth	Full Term?	CS or Vaginal	Length of Labor	Weight	Sex	Complications?
1							
2							
3							

4							
5							
6							
7							

FAMILY HISTORY

	Year of Birth	Diseases/Complications	Deceased? Y/N
Mother			
Father			
Sister(s)			
Brother(s)			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Other			

SOCIAL HISTORY

Are you a cigarette/cigar smoker? ☐Y ☐N Cig/day_____ Years of use _____ Are you ready to quit? ☐Y ☐N

Are you blind or have difficulty seeing? ☐Y ☐N Are you deaf or have difficulty hearing? ☐Y ☐N

Alcohol intake: (check one) ☐never ☐occasionally ☐daily

How many days in the past year have you had heavy drinking consumption (4+drinks) _____

Are you in recovery from drug or alcohol dependency? ☐Y ☐N Type_____

Do you have a current or past history of drug use (including misuse of prescription medications)? ☐Y ☐N

Caffeine: ☐Y ☐N amount/day: _____

Exercise level: (check one) ☐never ☐occasionally ☐moderate ☐heavy

Diet: (check one) ☐Vegan ☐Vegetarian ☐Gluten Free ☐Diabetic ☐No Restrictions

Marital Status: ☐ married ☐ domestic partner ☐ single ☐ divorced ☐ separated ☐ widowed ☐ unknown

Have you ever felt threatened or unsafe in a relationship? ☐Y ☐N ☐ Past relationship ☐ Current relationship

Education Level: (check one) ☐ High School ☐ 2yr College ☐ 4yr College ☐ Post Graduate

Occupation: _____

Religion: _____

Have you (or your partner) traveled to a zika-affected area in the past 12 months? ☐Y ☐N

Do you routinely use seat belts? ☐Y ☐N

Is a blood transfusion acceptable in an emergency? ☐Y ☐N

SURGICAL HISTORY

Name of Surgery	Date of Surgery

MEDICAL HISTORY (Please describe any medical conditions that apply to you)

☐Y ☐N Cancer_____
☐Y ☐N Heart Disease_____
☐Y ☐N Hypertension_____
☐Y ☐N Dermatology_____
☐Y ☐N Diabetes/Gestational Diabetes_____
☐Y ☐N Thyroid Problems_____
☐Y ☐N Abdominal Digestive Problems_____
☐Y ☐N Liver Disease _____
☐Y ☐N Blood Clots/Bleeding Disorder _____
☐Y ☐N History of Chicken Pox
☐Y ☐N Migraines_____
☐Y ☐N Seizures/Epilepsy_____
☐Y ☐N Bone Fractures as an Adult_____
☐Y ☐N Depression/Anxiety/Psychiatric Disorder
☐Y ☐N Asthma_____
☐Y ☐N Autoimmune Disorder_____
☐Y ☐N Urology_____
☐Y ☐N Weight Management_____

Other :

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Name:_____

REVIEW OF SYSTEMS

In the past 6 months have you experienced any of the following?
Please use the back to explain any "yes" answers.

Constitutional

Unexplained fever?	☐Y ☐N
Night sweats?	☐Y ☐N
Unexplained weight gain?	☐Y ☐N
Unexplained weight loss?	☐Y ☐N

Ear/Nose/Throat

Visual changes?	☐Y ☐N
Difficulty hearing?	☐Y ☐N
Frequent nose bleeds?	☐Y ☐N
Sore throat?	☐Y ☐N
Do you snore?	☐Y ☐N

Cardiovascular

Chest pain?	☐Y ☐N
Shortness of breath when at rest?	☐Y ☐N
Shortness of breath when walking?	☐Y ☐N

Respiratory

Persistent cough lasting >4weeks	☐Y ☐N
Seasonal allergies?	☐Y ☐N
Wheezing?	☐Y ☐N
Coughing up blood	☐Y ☐N

Gastrointestinal

Abdominal pain?	☐Y ☐N
Bloating?	☐Y ☐N
Change in appetite?	☐Y ☐N
Nausea or vomiting?	☐Y ☐N
Change in bowel pattern?	☐Y ☐N

Genitourinary

Leaking of urine (incontinence)?	☐Y ☐N
Frequent nighttime urination (nocturia)?	☐Y ☐N
Difficulty urinating?	☐Y ☐N
Painful urination?	☐Y ☐N
Increased frequency of urination?	☐Y ☐N

Musculoskeletal

Muscle aches?	☐Y ☐N
Muscle weakness?	☐Y ☐N
Joint pain?	☐Y ☐N
Back/neck pain?	☐Y ☐N

Integumentary

Skin changes?	☐Y ☐N
Abnormal mole?	☐Y ☐N

Neurologic

Change in headache pattern?	☐Y ☐N
Loss of consciousness?	☐Y ☐N

Psychiatric

Felt/feeling depressed or sad?	☐Y ☐N
Felt anxious?	☐Y ☐N
Sleep disturbances?	☐Y ☐N
Felt/feeling unsafe in a relationship?	☐Y ☐N
Dealt/dealing with an eating disorder?	☐Y ☐N

Endocrine

Heat/cold intolerance?	☐Y ☐N
Excessive hair growth?	☐Y ☐N
Increased thirst/hunger?	☐Y ☐N

Other

Bruise easily?	☐Y ☐N
Seasonal allergies?	☐Y ☐N

If you answered “yes” to any of the questions please explain:

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PELVIC HEALTH SURVEY

4/3/17

Name:_____ DOB : _____

Date:_____

BLADDER HEALTH

1. How often do you leak urine (only check one box)?
   - 0☐Never
   - 1☐About once a week or less
   - 2☐Two or three times a week
   - 3☐About once a day
   - 4☐Several times a day
   - 5☐All the time
2. When does urine leak (check all that apply)?
   - ☐Never-Urine does not leak
   - ☐Leaks before I can get to the toilet
   - ☐Leaks when I cough or sneeze
   - ☐Leaks even when I am asleep
   - ☐Leaks when I am physically active/exercise
   - ☐Leaks after I have finished urinating and get dressed
   - ☐Leaks for no obvious reason
   - ☐Leaks all the time
3. Overall, how much does leaking urine interfere with your daily life?
   Please circle a number between 0(not at all) and 10(a great deal)

0 1 2 3 4 5 6 7 8 9 10

(not at all) (a great deal)

BOWEL HEALTH

1. Do you accidentally leak stool? ☐NO ☐YES
2. Do you strain to have bowel movements? ☐NO ☐YES
3. Do you pass gas when you do not want to? ☐NO ☐YES

OB/GYN HISTORY

1. Have you ever had a baby vaginally? ☐NO ☐YES#_____
2. Have you ever had a baby by Cesarean Section? ☐NO ☐YES#_____
3. If you have had a baby what was her or his weight at delivery?

_____lbs_____oz _____lbs_____oz _____lbs_____oz

_____lbs_____oz _____lbs_____oz _____lbs_____oz

4. If you have had a baby vaginally did you have a vaginal tear? ☐NO ☐YES

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name:_____ Date of Birth:_____

Provider:_____ Today's Date :_____

Instructions: Please check yes for those that apply to **YOU and/or YOUR FAMILY** on both your mother's (maternal) or father's (paternal) side.
You and the following family members should be considered:

Mother	***Maternal Uncle/Aunt***	***Maternal Grandmother/Grandfather***
Father	***Paternal Uncle/Aunt***	***Paternal Grandmother/Grandfather***
Brother	***First Cousins***	
Children	***Niece/Nephew***	

			(if yes then who)		
COLON and UTERINE CANCER	*YES*	*NO*	*Self*	*Family Member*	*Age at diagnosis*
Uterine(endometrial) cancer before 50					
Colorectal cancer before age 50					
Two or more Lynch Syndrome cancers* in the same person or on the same side of the family					

(*Lynch Syndrome cancers include: Colon, Rectal, Uterine, Ovarian, Stomach, Gall Bladder Duct, Intestinal, Pancreas and Brain)

			(if yes then who)		
BREAST and OVARIAN CANCER	*YES*	*NO*	*Self*	*Family Member*	*Age at diagnosis*
Breast cancer at age 50 or younger					
Ovarian cancer					
Two primary (unrelated) breast cancers in the same person or on the same side of the family					
Male breast cancer					
Triple negative breast cancer (ER-,PR-HER2-pathology)					
Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family					
Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family					
Have you or any member of your family ever been tested for hereditary risk of cancer					

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ADVANCED ANNUAL NOTICE

Dear Patient,

You are scheduled for your annual pap smear, breast and pelvic examination today. Our normal fee for this service is $160 for established patients and $200 for new patients. Any lab work (pap smear, blood work) that may be associated with the exam will be billed by the laboratory directly. **If you have health insurance that we will be billing for you today and you do not have a benefit for this exam, you will be responsible for this fee.** The laboratory will bill you separately for those charges.

If you have other medical concerns not related to your annual exam that you would like to discuss with the doctor at the same time and it meets necessity to bill additionally for this service, we will do so. By signing this form, you are confirming your agreement to assume financial responsibility for payment of these charges should your insurance find them not medically necessary or non-covered.

Patient Signature: _____ Date: _____