HEART OF FLORIDA OB/GYN

All Information is Confidential

Acct.#:_____

GENERAL PATIENT INFORMATION

Name: Last_____ First_____ MI_____

Sex: F___ M___ Date of Birth:_____ _____ Age:_____

Social Security #_____-_____-_____ Status: Single___ Married___ Widowed___

Mailing Address:_____

City_____, State_____, Zip Code_____

Phone: Home_____ Cell_____

Work_____ Other_____

Guarantor:_____ Phone #:_____
(if patient under 18yrs)

M / F Date of Birth:_____ SSN:_____

Email Address:_____
(ONLY to be used if all other means of contact fail & Patient Portal invite)

How did you hear about HOFOBGYN:_____

EMERGENCY CONTACT

Whom should we contact in case of emergency:_____

Phone: _____ Relationship:_____

Phone: _____ Relationship:_____

Race:_____ Ethnicity:_____

Primary Language spoken by patient:_____
If other than English, please plan to have a translator with you. Some staff members speak Spanish, but are not available for translation during a visit with providers. If a staff member is required to translate for you, there will a $10 fee collected at the time of the visit.

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ Effective Date:_____

ID#_____ Group#_____

Insured's Name:_____ SSN:_____

Relationship: Self____ Spouse_____ Child_____ Other_____ Insured's DOB:_____

SECONDARY INSURANCE:_____ Effective Date:_____

ID#_____ Group#_____

Insured's Name:_____ SSN:_____

Relationship: Self____ Spouse_____ Child_____ Other_____ Insured's DOB:_____

Payment Method: Cash_____ Check_____ Visa_____ MasterCard_____
Discover_____

Balance must exceed $20 if using a credit/debit card

REFERRING PHYSICIAN:_____ Phone:_____

PRIMARY CARE PHYSICIAN:_____ Phone:_____

OCCUPATION INFORMATION

Patient's Employer:_____ Phone:_____

Position:_____ FT / PT / Seasonal / Temporary

Spouse's Employer:_____ Phone:_____

Position:_____ FT / PT / Seasonal / Temporary

HEART OF FLORIDA OB/GYN ASSOCIATES
HEALTH HISTORY FORM

Name:_____ DOB:_____ Date:_____

Drug Allergies & Reactions:
Drug:_____ Reaction:_____

Drug:_____ Reaction:_____

Drug:_____ Reaction:_____

List any other allergies & reactions:_____

Have you had any special immunizations? What & when were they? (i.e. smallpox, malaria, hepatitis):_____

List any pertinent family history & relationship to you:

1-Cancer	2-Congenital Heart Defect	3-Thalassemia	4-Neural Tube Defect
5-Hemophilia	6-Muscular Dystrophy	7-Down Syndrome	8-Sickle Cell
9-Diabetes	10-Huntington Chorea	11-Tay Sachs	12-Cystic Fibrosis
13-PKU	14-Psychological Disorder	15-Birth Defect	16-Retardation
17-Autism	18-Pregnancy Complication	19-Recurrent Pregnancy Loss	

Explain by Number Above:_____

_____

_____

MEDICAL HISTORY: (circle all that apply)

High Blood Pressure	Scarlet Fever	Bronchitis	Ulcers
Heart Disease	Polio	Sinusitis	Gallstones
High Cholesterol	Shingles	Asthma	Hepatitis
Gastro-Intestinal Disease	AIDS	Tuberculosis	Hemorrhoids
Rheumatic Fever	HIV	Pneumonia	Stroke
Varicose Veins	Diabetes	Cancer	Anemia
Pulmonary Disease	Anxiety Attacks	Thyroid Disease	Lupus
Urinary Tract Infection	Kidney Disease	Suicide Attempt	Epilepsy
Psychological Disorder	Autoimmune Disorder	Migraines (diagnosed by a neurologist)	

Other:_____

Surgeries & Hospitalizations:	Why:	Dates:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name:_____ DOB:_____ Date:_____

SOCIAL HISTORY:
Do you smoke? Yes / No If yes, how much?_____ /day
Do you drink? Yes / No If yes, how much?_____ /day
Do you use any street drugs? Yes / No If yes, what & how much?_____
_____

MEDICATION(S): List all present medications, dosages & reason for med:

Medication & Dosage	How/When Taken	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREGNANCY HISTORY:
How many pregnancies?_____ Include miscarriage, stillbirth, preterm, etc.
How many children born: Alive?_____ Stillborn?_____ Cesarean Sections?_____
Complications:_____

MENSTRUAL HISTORY:
Age at 1st period:_____ # of pads/tampons used per cycle:_____ First day of last period:_____
Do you have regular cycles? Yes / No Do you have (circle all that apply): Clots / Cramps / Pain
Explain above (if necessary)_____
Do you have any vaginal discharge? Yes / No Color:_____ Amount_____
Odor:_____ Frequency_____

SEXUAL HISTORY:
Are you sexually active?_____ Birth Control Type:_____
How long on present birth control?_____

# of Current Partners:_____ Male, Female, Both, Other:_____ Protection Used: Yes / No
# of Partners in last year:_____ Male, Female, Both, Other:_____ Protection Used: Yes / No
# of Partners in your lifetime (approximate):_____

Have you ever had any sexually transmitted disease? (Circle all that apply)
Syphilis Gonorrhea Chlamydia Genital Herpes Genital Warts Trichomonas Crabs HIV

Do you think you are at any increased risk for any sexually transmitted disease, HIV, hepatitis? Yes / No

Have you had sex with any partner that is not from the United States in the past 2 years?_____
From what country/nation is/was your partner from?_____
Was a condom used?_____ Have you ever been treated for pelvic inflammatory disease?_____

(This office does not mean to offend anyone by asking the above questions)

PATIENT SIGNATURE FORM

ADVANCED DIRECTIVE ("Living Will")

I have read the information provided on *Advanced Directive*. I have been offered an advanced directive today. Please ***INITIAL*** the line below that applies.

_____I decline at this time.
_____I accept at this time, will complete the form & return it to the office.
_____I have an advanced directive and will supply a copy to this office.

PAYMENT RESPONSIBLITY

I understand that I am responsible for all medical/supply charges. Payment is required at the time of service. This office has my permission to file medical insurance claims on my behalf. I will ultimately be responsible for all expenses incurred if payment

Signed:_____ Date:_____

OFFICE POLICIES FOR PATIENTS

I have read the *OFFICE POLICIES FOR PATIENTS* provided to me. I understand and agree to abide by these policies.

Signed:_____ Date:_____

HIPAA PATIENT CONSENT

I have read and understand the *HIPAA Patient Consent Form*.

Signed:_____ Date:_____

FINANCIAL POLICY

I have read and acknowledge the *Financial Policy* form provided to me by Heart of Florida Ob/Gyn Associates.

Signed:_____ Date:_____