

Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth	Social Security Number		
Patient's Address		City	State	Zip	
Home Phone		Mobile Phone	Email Address		
Referred by		Primary Care Physician	Primary Care Physician Phone		
Pharmacy	Pharmacy Phone	Pharmacy Address			

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone		
Employer/School Address		City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient
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Billing and Insurance

Primary Health Insurance

Insurance Company		Plan		
Plan Number	Group Number	Insured's Employer/School		
Insured's Name(as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number	
Insured's Address		City	State	Zip
Insured's Social Security Number	Insured's Birthdate			

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name(as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient	
Address	City	State	Zip

Notice of HIPPA practices acknowledgement: I have read and understand the Notice of Privacy Practices.

I hereby authorize the Physicians of Gentle Gynecology & Obstetrics or Staff to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim. I also authorize the Physicians of Gentle gynecology & Obstetrics or Staff to obtain medical records from other facilities or Physicians for my continued medical care. This may include but is not limited to the following reports; Pap smear, pathology, pelvic sonograms, breast imaging, Obstetrical imaging specialist reports, and laboratory results that may include H.I.V. results & diagnosis. This release is valid for 1 year from signature.

Signature of Patient or Authorized Guardian

Date

Check-In by

Patient Responsibilities

PHI (PROTECTED HEALTH INFORMATION) DISCLOSURE

We cannot discuss your PHI (protected health information) with anyone than yourself unless you authorize us to do so. Please list below the name(s) of the individual(s) you authorize our office to discuss your care with. Your PHI will be disclosed to the individual(s) listed below until you notify us otherwise in writing.

1. _____ 2. _____

This authorization will remain in effect for one year unless otherwise specified. I understand this authorization extends to all or any part of my medical records. I expressly consent to the release of information as designated above. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained.

If you opt for HIV screening, these results will only be given in person to the patient per HIPPA guidelines. This is the "LAW".

The doctors and staff at Gentle Gynecology & Obstetrics would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible. **Please be advised that Dr. Augustino & Dr. Achille will only perform Surgery and Deliver at Memorial Hospital West.** If you seek care at any other hospital other than Memorial Hospital West, Dr. Augustino & Dr. Achille will be unable to care for you while you are at that facility.

RELEASE OF MEDICAL RECORDS: If you wish to release your records to yourself, another physician or someone else, **written consent is required by law.** We will process the request and most requests are handled within ten (10) business days. (Fees may apply... see release of records form for more information.)

FINANCIAL POLICY

BY INITIALING AND SIGNING BELOW YOU CONFIRM THAT YOU HAVE READ THIS POLICY AND UNDERSTAND THAT:

INSURANCE AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize Gentle Gynecology & Obstetrics to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested the medical service of Gentle Gynecology & Obstetrics on behalf of myself and/or dependents, and I understand by making this request, I become fully financially responsible for any and all charges occurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, Medicaid, private insurance and any other health/medical plan to issue payment directly to gentle gynecology & obstetrics, for medical service rendered to myself and/or my dependents regardless of my insurance benefits, if any.

I understand that not all services are covered benefits and I am responsible for any amount not paid, regardless of insurance policy. All Self Pay patients are responsible for any and all FEES for blood, cultures or sonogram testing. These fees are NOT PART of the office visit charge.

Medical malpractice: We have elected not to carry medical malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to s-458.320 (5)(g). Florida law imposes penalties against non-insured Physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida law.

Patient Responsibilities

- It is your responsibility to know your insurance benefit plan, copays, co-insurance & patient responsibilities. If you are not sure of your coverage contact your insurance carrier's customer service department. We are not responsible to explain your individual insurance benefits to you.
- It is your responsibility to inform our office of any address or telephone number changes. Your account is to be kept current accordingly; all self-pay or insurance co-payments, co-insurance and deductibles will be collected at the time of services. Payable by: cash, check, Visa, MasterCard, and Discover.
- If you do not have payment(s) due at your visit your appointment may be rescheduled.
- A returned check will result in a \$25 service charge and all future payment being required in the form of CASH or CREDIT CARD.
- After a second of completion of forms for Disability, FMLA, etc.... there will be a \$10 charge for each additional form completion. (Allow 7 business days for completion.)
- If unable to keep your appointment, please notify us 24 hours in advance so that we may offer that time to another patient. A pattern of repetitive "no show" or late cancellations may regretfully result in an assessment of a cancellation/no show fee of \$25 for each incident and or dismissal from our practice.
- If your insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral faxed to our office prior to your appointment. If we do not receive your referral your appointment may be rescheduled.
- Doctor's collection fee for fetal Cord Blood at time of delivery is \$400.00 and must be paid in full by the 28th week of pregnancy. Initials _____

All Self-Pay patients are responsible for any and all TESTING FEES (blood, cultures, sonogram, etc.) these fees are collected at the time services are rendered. These fees are NOT PART of the office visit charge.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. **We are here to help you.**

I have read and fully understand the above Financial Policy and agree to meet all financial obligations.

Signature (Patient's Parent/Guardian, if a Minor) _____

Date _____

Consent for Voice and Text Message Communication

In an effort to relay **Normal results** faster to our patients we have implemented Electronic Medical Records. I understand that in order for Gentle Gynecology & Obstetrics to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to Gentle Gynecology & Obstetrics.

I further understand that in order for Gentle Gynecology & Obstetrics to Text detailed messages containing specific medical information to my cell phone, I need to give my written express permission to Gentle Gynecology & Obstetrics.

I also understand that my healthcare information at Gentle Gynecology & Obstetrics is protected and a copy of the Notice of Privacy Practices is available upon my request.

Consent for Messages:

I give my written express consent to Gentle Gynecology & Obstetrics to leave detailed messages on my voicemail/answering machine about my **NORMAL** lab, ultrasound, breast imaging, prescription information, reminders or Pap smear results. I also give my written express consent that this information may be communicated to me via Text message.

I understand that “sensitive” information as noted below will be excluded.

- **No abnormal results** will be communicated via our automated system.
- **No HIV results** are disclosed by phone, mail email or text. HIV results are only given in person to the patient as stipulated by H.I.P.P.A. Law.

Patient Name (**Please Print**)

Patient Signature

Date

Cell: (This number will be used for messaging)

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time.

I understand that I must provide written notice to Gentle Gynecology & Obstetrics in order to revoke this consent.

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

How is your general health?
 Excellent Good Fair Poor

Height:

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Are you allergic to any of the following?
 Adhesive Tape Antibiotics Latex
 Barbiturates(Sleeping Pills) Aspirin Iodine
 Codeine Sulfa Local Anesthetics
Do you have any other allergies?

Name	Reaction
_____	_____
_____	_____

Past Medical History

- Alcoholism Back Problems Ear Problems Hepatitis - A, B, or C Measles Skin Disorder
- Allergies Bleeding Disorder Eating Disorder High Blood Pressure Migraines Stomach Ulcer
- Anemia Blood Disease Epilepsy High Cholesterol Osteoporosis Substance Abuse
- Anxiety Disorder Blood Transfusion Glaucoma Joint Disorder Pneumonia Thyroid Disorder
- Arthritis Cancer Gout Kidney Disorder Polio Tuberculosis
- Asthma Diabetes Heart Disease Liver Disorder Rheumatic Fever Venereal Disease
- AIDS / HIV Depression Heart Problems Lung Disease Stroke

Hospitalizations & Surgeries

Reason _____ Date _____
Reason _____ Date _____

Lifestyle Factors

Are you sexually active?
 Yes No # of partners in past year _____
Do you wish to be checked for STDs?
 Yes No
Has anyone in your home ever physically or verbally hurt you?
 Yes No
Have you ever smoked?
 Yes No # of years _____ # packs/day _____
Do you smoke now?
 Yes No # packs/day _____
Do you use recreational drugs?
 Yes No types? _____ # times/week _____
How much alcohol do you drink per week?
drinks/week _____
How much caffeine do you drink per day?
drinks/day _____
How often do you exercise?
times/week _____

Family History

Has anyone in your family ever had any of the following conditions?

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> Joint Disorder
<input type="checkbox"/> Allergies	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Disorder
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/> Migraines
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Psychiatric Disorders
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disorder

Details:

Name _____ Gender _____ Age _____

Date of Appointment: _____

OBGYN History

Have you ever had or do you currently have any of the following?

- Abnormal Vaginal Bleeding
- Abnormal Pap Smear
- Bleeding between Periods
- Breast Lump
- Breast Cancer
- Breast Surgery
- Cervical Cancer
- Chlamydia
- Colposcopy
- Cryosurgery
- DES Exposure
- Extreme Menstrual Pain
- Fibroids
- Genital Warts
- Gonorrhea
- Herpes
- Hot Flashes
- HPV
- Infertility
- Irregular Periods/Bleeding
- Nipple Discharge
- Ovarian Cysts
- Ovarian Cancer
- Painful Intercourse
- Pelvic Inflammatory Disease
- Uterine Cancer
- Urinary Incontinence
- Yeast Infections – Frequent

Pregnancy History

Please describe any pregnancies you have had.

of Pregnancies _____ # of Full Term _____ # of Miscarriages _____ # of Abortions _____

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Were there any complications associated with any of your pregnancies?

Are you currently pregnant?

Yes No

Are you trying to become pregnant?

Yes No

Do you need birth control or contraceptive advice?

Yes No

What method of birth control do you use?

Menstrual History

When was the first day of your last period?

How often does your period occur?

How long does your period last?

Is your period regular?

Yes No

What age were you when you had your first period?

What age were you at menopause?

Health Exams & Procedures

Please check and date all immunizations you have had.

	Month & Year	Results
<input type="checkbox"/> Blood Sugar-Fasting	_____	_____
<input type="checkbox"/> Breast Self Exam	_____	_____
<input type="checkbox"/> Cholesterol Test	_____	_____
<input type="checkbox"/> Colonoscopy	_____	_____
<input type="checkbox"/> CT/CAT Scan	_____	_____
<input type="checkbox"/> Dexascan (Bone Density)	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Echocardiogram	_____	_____
<input type="checkbox"/> Fecal Occult Blood Test	_____	_____
<input type="checkbox"/> Mammogram	_____	_____
<input type="checkbox"/> MRI	_____	_____
<input type="checkbox"/> Pap Smear	_____	_____
<input type="checkbox"/> Physical Exam	_____	_____
<input type="checkbox"/> Cardiac Stress Test	_____	_____
<input type="checkbox"/> Ultrasound	_____	_____

Check-In by _____

Name _____ Gender _____ Age _____

Date of Appointment: _____

Review of Systems

General

- Chills
- Dizziness
- Fainting
- Fever
- Hair Loss
- Hair Growth – Excessive
- Night Sweats
- Sleeping Problems
- Thirst - Excessive
- Weight Gain
- Weight Loss

Mental Health

- Anxiety
- Depression
- Loss of Interest
- Feeling Hopeless
- Hearing Voices
- Marital Problems
- Panic Attacks
- Trouble Concentrating
- Suicide –Thoughts/Attempts

Musculoskeletal

- Back Pain
- Carpal Tunnel Syndrome
- Joint Pain
- Joint Swelling
- Neck Pain
- Shoulder Pain

Gastrointestinal

- Appetite Gain
- Appetite Loss
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Gas
- Hemorrhoids
- Indigestion
- Intestinal Disorder
- Lactose Intolerance
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting Blood

Genitourinary

- Blood in Urine
- Lack of Bladder Control
- Frequent Urination
- Painful Urination

Respiratory

- Coughing
- Coughing Up Blood
- Shortness of Breath
- Wheezing

ENT

- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Difficulty Swallowing
- Double Vision
- Earaches
- Ear Discharge
- Hay Fever
- Hoarseness
- Hearing Loss
- Nose-Bleeds
- Persistent Cough
- Persistent Runny Nose
- Recurring Sore Throat
- Ringing in Ears
- Sinus Problems
- Vision Halos

Cardiovascular

- Chest Pains
- Irregular Heart Beat
- Circulation Problems
- Heart Palpitations
- Rapid Heartbeat
- Swelling of Ankles
- Varicose Veins

Skin

- Acne
- Bruise Easily
- Changes in Moles
- Dry / Sensitive Skin
- Eczema
- Hives
- Itching
- Rash
- Scars
- Sores That Won't Heal

Neurological

- Coordination Problems
- Convulsions
- Difficulty Walking
- Learning Disabilities
- Light-headedness
- Memory Loss
- Numbness / Tingling
- Paralysis
- Seizures
- Speech Problems
- Tremors

Other Symptoms

Race

This information is needed for prenatal testing. Please feel free to ask your doctor any question you may have regarding information gathered.

- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- Black or African American
- White
- Asian
- Hispanic or Latino
- Not Hispanic or Latino

Check-In by _____

Welcome to Gentle Gynecology & Obstetrics. For those of you who are new to our practice, we will strive to meet your expectations. For those of you who were patients of Dr. Augustino before, we appreciate your support and true confidence you have in our practice.

Please be advised that Dr. Augustino & Dr. Achille will only perform Surgery and Deliver at Memorial Hospital West. If you seek care at any other hospital other than Memorial Hospital West, Dr. Augustino & Dr. Achille will be unable to care for you while you are at that facility.

Please note Doctors Augustino & Achille will have On-Call coverage with other OB/GYN physicians. These Doctors will also be available in case of any unforeseen emergency, vacation, seminar, etc.

We encourage a strong physician/patient relationship, as a group practice we cannot guarantee which provider will be on call at the time of your delivery. Therefore we suggest you meet both doctors at our practice at least once during your pregnancy. Once again, we welcome you to our practice. Please do not hesitate to ask questions or voice any concerns.

Patient Signature

Date

Name of Patient (Please Print)

Witness Signature