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 (Age)	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

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.
May we leave a detailed message on your voice mail: ____Yes ____ No (________)____________________________

I herby 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 & records 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 REGISTRATION

PHI (PROTECTED HEALTH INFORMATION) DISCLOSURE
We cannot discuss your protected health information (PHI) 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.

RELEASE OF MEDICAL RECORDS
If you wish to release your records to yourself, another physician or someone else, **you must sign a release**. 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
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.

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.

Initials __________

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.

Initials __________

· 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), 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.

· There is a $10 charge for each request of completion for paperwork (ex: Disability, FMLA, etc…..)

· For our Gynecology patients there is a $15 charge for each blood draw. For Obstetrical patients a 1 time fee of $40 for routine tests required in pregnancy. Bio-Identical patients are not subject to these charges for tests related to Hormone Therapy.

Initials __________

· 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.**

· 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.

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 understand the above Financial Policy and agree to meet all financial obligations.

______________________________________ ______________________________________
Signature (Patient's Parent/Guardian, if a Minor **Date**

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
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
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
Name	Reaction
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
Reason	Date

Family History

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

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

Details:

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 ________

Check-In by

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
[ ] Blood Sugar-Fasting		
[ ] Breast Self Exam		
[ ] Cholesterol Test		
[ ] Colonoscopy		
[ ] CT/CAT Scan		
[ ] Dexascan (Bone Density)		
[ ] EKG		
[ ] Echocardiogram		
[ ] Fecal Occult Blood Test		
[ ] Mammogram		
[ ] MRI		
[ ] Pap Smear		
[ ] Physical Exam		
[ ] Cardiac Stress Test		
[ ] 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 you 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

Michael F. Augustino, M.D., F.A.C.O.G.
Fabienne Achille, M.D., F.A.C.O.G.

Welcome to Gentle Genecology & 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**