

PATIENT INFORMATION FORM

PHARMCY _____ DOCTOR/MIDWIFE _____
PRIMARY CARE DOCTOR _____ PRIMARY CARE DOC. PH# _____ FAX# _____
NAME _____ SEX ☐ M ☐ F RACE _____ ETHNICITY _____
SOCIAL SECURITY# _____ BIRTHDATE _____ MARITAL STATUS ☐ S ☐ M ☐ W ☐ D
RELIGION _____ AGE _____ HOME PH.# () _____ CELL PH: # _____
STREET ADDRESS _____ APT. _____
CITY _____ STATE _____ ZIP _____
DRIVER'S LICENSE # _____ EMAIL _____
EMPLOYER/SCHOOL _____ TITLE _____ PHONE # () _____
STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____
SPOUSE _____ AGE _____ BIRTHDATE _____
SPOUSE EMPLOYER _____ TITLE _____ PHONE # () _____
STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____
TRANSLATOR NEEDED ☐ YES ☐ NO PRIMARY LANGUAGE SPOKEN _____ REFERRED BY _____

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY, OTHER THAN SOMEONE LIVING WITH YOU:

NAME _____ PHONE () _____ RELATIONSHIP _____
STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

FATHER'S NAME _____ MOTHER'S NAME _____
EMPLOYED BY _____ EMPLOYED BY _____
POSITION _____ POSITION _____
PHONE _____ PHONE: _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. _____
ADDRESS _____
CITY/STATE/ZIP _____
PHONE # _____
ID# _____
GROUP NAME OR # _____
INSURED'S FULL NAME _____
IS THIS AN EMPLOYER PLAN? _____
INSURED'S SOCIAL SEC # _____
INSURED'S D.O.B. _____
RELATIONSHIP TO INSURED _____
(Self — Husband — Wife — Child — Other)

SECONDARY INSURANCE INFORMATION

INSURANCE CO. _____
ADDRESS _____
CITY/STATE/ZIP _____
PHONE # _____
ID# _____
GROUP NAME OR # _____
INSURED'S FULL NAME _____
IS THIS AN EMPLOYER PLAN? _____
INSURED'S SOCIAL SEC # _____
INSURED'S D.O.B. _____
RELATIONSHIP TO INSURED _____
(Self — Husband — Wife — Child — Other)

GUARANTEE OF PAYMENT

I fully understand that I am directly responsible for payment to the Physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physicians in this office 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.

ASSIGNMENT OF INSURANCE BENEFITS

If insurance claims are filed by this office on my behalf. I hereby authorize direct payment of any benefits to the Physicians in this office for the medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization to be used in place of the original.

Signature _____ Date _____
(Patient's parent, if minor)

Authorization to Discuss Protected Health Information*

I _____, authorize _____

to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named persons**.

1. _____ 3. _____
2. _____ 4. _____

- * PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL NOT BE GIVEN ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.
- ** YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

Please list phone numbers where you would like us to contact you for:

- Results - lab, X-ray, Ultrasounds, Mammograms, etc.
- Reminder notices
- Changes on scheduled appointments

1. _____
2. _____

Patient's name: _____

DOB: _____

SS#: _____

Date: _____

Patient's Signature: _____

ADVANCE DIRECTIVE

DO YOU HAVE AN ADVANCE DIRECTIVE / LIVING WILL? _____ IF YES, PLEASE PROVIDE US WITH A COPY FOR OUR RECORDS.

IF NO, PLEASE LET US KNOW IF YOU REQUIRE INFORMATION.

I hereby authorize the use of and/or disclosures of any telephone number, provided by me or on my behalf, that is assigned to a residential line, cellular telephone service, paging service, facsimile machine, computer, or any other service or device for which the called party is charged for the call for the purpose of billing and collecting payment for medical services rendered to me. This consent applies to any call made using automatic telephone dialing system or an artificial or prerecorded voice.

QUALITY WOMEN'S CARE OF FLORIDA, LLC

Susan Davila, M.D., F.A.C.O.G.
Karen Hirschberg, M.D., F.A.C.O.G.
Martha L. Garzon, M.D., F.A.C.O.G.

Carmen Selman, M.D., F.A.C.O.G.
Monica Giardino, C.N.M., A.P.R.N

NAME: _____ INSURANCE CO. _____

PRIMARY DR. _____ TELEPHONE NO. _____

DATE OF BIRTH: _____ AGE _____

REASON FOR VISIT: _____

LAST MENSTRUAL PERIOD: _____

Duration: _____ Period Interval: _____
(DAYS)

LAST PAP SMEAR: _____

LAST MAMMOGRAM: _____

PREGNANCY: _____
Number abortions miscarriages

DELIVERY: (month/year)	SEX	TYPE OF DELIVERY	COMPLICATIONS
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

TOBACCO (CIG/DAY) _____

ALCOHOL (OZ/WEEK) _____

WHAT IS THE PRIMARY LANGUAGE YOU SPEAK? _____

DRUG ALLERGIES: _____

TURN PAPER OVER TO COMPLETE

Quality Women's Care of Florida, LLC

1150 N. 35th Avenue, #400 • Hollywood, FL 33021 • (954) 963-6363 (Fax) 963-4447
601 N. Flamingo Road, #205 • Pembroke Pines, FL 33028 • (954) 431-1211 (Fax) 431-9298

QW314

PAST MEDICAL HISTORY:

(Please check if you have had any of the following conditions):

HIGH BLOOD PRESSURE _____
HEART DISEASE _____
DIABETES _____
BOWEL DISORDERS _____
KIDNEY PROBLEMS _____
ASTHMA _____
GALL BLADDER DISEASE _____
THYROID DISEASE _____
CANCER _____
BLOOD TRANSFUSIONS _____

**SEXUALLY TRANSMITTED
DISEASES:**

CHLAMYDIA _____
HERPES _____
OTHER _____

PERTINENT FAMILY HISTORY: _____

PAST SURGICAL HISTORY:

	YEAR	OPERATION	REASON	COMPLICATIONS
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

MEDICATIONS:

NAME	DOSE	REASON
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

I authorize this office to release any medical information about me to my insurance company/primary physician's office.

SIGNATURE: _____ **DATE:** _____

QUALITY WOMEN'S CARE OF FLORIDA, LLC.

*Susan Davila, M.D., F.A.C.O.G., Karen Hirschberg, M.D., F.A.C.O.G.,
Martha Garzon, M.D. F.A.C.O.G., Carmen Selman, M.D F.A.C.O.G.,
Monica Giardino, C.N.M., A.P.R.N.*

Practice Limited to Obstetrics and Gynecology and Infertility

*1150 N. 35th Avenue, #400
Hollywood, Florida 33021
(954)963-6363 (954) 963-4447*

*601 N. Flamingo Road, Suite #205
Pembroke Pines, Florida 33028
(954)431-1211 (Fax) 431-9298*

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge that there was a copy of the Notice of Privacy Practices posted describing how my health information may be used or disclosed under the federal law. Provided that Quality Women's Care of Florida, LLC continues in its good faith effort to comply with the requirements of the federal privacy act law. I hereby consent to the use and disclosure of my health information for the purposes and the activities permitted under the federal privacy act law, which are described in the Notice of Privacy Practices posted in the lobby.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the notice may be changed at any time. I may obtain a revised copy of the notice by calling (954) 431-1211 or (954) 963-6363 or by requesting once at our office.

I also authorize Susan Davila, M.D., Karen Hirschberg, M.D., Martha Garzon, M.D., Carmen Selman, M.D., Monica Giardino, C.N.M., A.P.R.N., and staff to release all medical information to the following:

Name

Relationship to Patient

Name

Relationship to Patient

Patient Name

Date

Signature of Patient

QUALITY WOMEN'S CARE OF FLORIDA, LLC.

Susan Davila, M.D., F.A.C.O.G., Karen Hirschberg, M.D., F.A.C.O.G.,
Martha Garzon, MD., F.A.C.O.G., Carmen Selman, M.D., F.A.C.O.G.,
Monica Giardino, C.N.M., A.P.R.N.

Practice Limited to Obstetrics and Gynecology and Infertility

Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Quality Women's Care of Florida; LLC to apply for benefits on my behalf for covered services rendered by him/her or his/her order. I request that payment from my insurance company be made directly to Quality Women's Care of Florida, LLC.

I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am financially responsible for all charges including costs of collection and litigation if necessary.

Date: _____ Signature _____
(Patient, Parent, or Guardian)

Physician Financial Responsibility

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgement arising from claims of medical malpractice. This notice is pursuant to Florida law.

Date: _____ Signature _____
(Patient, Parent, or Guardian)

Medical Malpractice Agreement

Further, I understand that I am entering into a contractual relationship with Quality Women's Care of Florida, LLC for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Quality Women's Care of Florida, LLC, I (the patient) and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claims of medical malpractice against Quality Women's Care of Florida, LLC.

Furthermore, should a meritless medical malpractice case or cause of action be initiated or pursued. I (the patient) and/or my representative agree to use ABMS board- certified expert medical witness (es) in the same or similar specialty as Quality Women's Care of Florida, LLC. Furthermore, I agree that these expert witnesses (es) will adhere to the guidelines and/or code of conduct defined by the specialty society (ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, Quality Women's Care of Florida, LLC, agree to the same stipulations.

Date: _____ Signature _____
(Patient, Parent, or Guardian)

Patient: _____ Date: _____
 Current Medication: _____
 Allergies: _____
 Last Menstrual Period: _____ Cycle Frequency: _____ Duration: _____
 Flow: _____

General Questions

Birth Sex: Male or Female

Gender Identity: ☐ Male
☐ Female
☐ Female to Male (FTM) / Transgender Male / Trans Man
☐ Male to Female (MTF) / Transgender Female / Trans Woman
☐ Genderqueer, neither exclusively male nor female
☐ Choose not to disclose
☐ Additional Gender category or other, Please specify _____

Transgender: Yes or No

Sexual Orientation: ☐ Lesbian, gay or homosexual
☐ Straight or heterosexual
☐ Bisexual
☐ Do Not Know
☐ Choose not to disclose
☐ Something else, Please describe _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No

General

Have you gained or lost weight recently?	Y	N
How many pounds? _____		
Did you have a flu shot this year?	Y	N
If not, Do you plan to?	Y	N

Integumentary

Skin rash	Y	N
Nipple discharge	Y	N
Persistent itch	Y	N

Neurological

Trouble Sleeping	Y	N
Headache	Y	N
Seizures	Y	N
Other: _____		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Frequent urination	Y	N
Other: _____		

Patient: _____ Date: _____

Endocrine

Excessive Thirst Y N
Too hot/cold Y N
Tired/Sluggish Y N
Other: _____

Respiratory

Asthma Y N
Frequent cough Y N
Shortness of breath Y N
Other: _____

Gastrointestinal

Abdominal Pain Y N
Nausea/Vomiting Y N
Indigestion/heartburn Y N
Other: _____

Hematologic/Lymphatic

Swollen glands Y N
Blood clotting problem Y N
Anemia Y N

Cardiovascular

Chest Pain Y N
Varicose veins Y N
High blood pressure Y N
Other: _____

Psychiatric

Are you unhappy with your life? Y N
Do you feel severely depressed? Y N
Have you considered suicide? Y N
Other: _____

Safe Sex Y N
Sexually Active (if so, # of partners : _____) Y N
STD History Y N
Smoking Y N
Alcohol (if so, how much? : _____) Y N

Self Breast Exam Y N
Diet and Exercise Y N
Sunscreen Y N
Domestic Violence Y N
Recreational Drugs Y N
Wear Seat Belt Y N

Physician Reviewed: _____

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

Patient Name: _____
Date of Birth: _____

Physician: _____
Today's Date: _____

This is a screening tool for cancers that run in families. Please consider these family members when completing the form:

Mother/Father/Sister/Brother/Children = 1st Degree Relatives

Aunt/Uncle/Grandparent/Niece/Nephew = 2nd Degree Relatives Cousin/Great Grandparent = 3rd Degree Relatives

Have you or any of your relatives been tested for hereditary cancer (BRCA/Colaris) in the past? YES NO

COLON AND UTERINE CANCER (Lynch Syndrome/Colaris)		SELF	YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
			MOTHER'S SIDE	FATHER'S SIDE	
☒ Y	☐ N			Aunt-colon Sister-uterine	47 yrs 60 yrs
☐ Y	☐ N				
☐ Y	☐ N				
☐ Y	☐ N				
☐ Y	☐ N				

BREAST AND OVARIAN CANCER (HBOC/BRCA Analysis)		SELF	YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
			MOTHER'S SIDE	FATHER'S SIDE	
☐ Y	☐ N				
☐ Y	☐ N				
☐ Y	☐ N				
☐ Y	☐ N				
☐ Y	☐ N				
☐ Y	☐ N				
☐ Y	☐ N				
☐ Y	☐ N				
☐ Y	☐ N				
☐ Y	☐ N				

Is there any other cancer in you or any family members not listed above (provide site, relationship and age): _____

Patient's signature: _____

Date: _____

FOR OFFICE USE ONLY	
☐ Patient is appropriate for further risk assessment and/or genetic testing	
☐ Information given to patient to review	Follow-up appointment scheduled on _____
☐ Patient offered genetic testing: Accepted OR Declined	HGP Signature: _____

Cuestionario sobre antecedentes familiares para síndromes comunes de Cáncer Hereditario

Nombre: _____
 Fecha de nacimiento: _____

Médico: _____
 Fecha de hoy: _____

Este cuestionario se utiliza para identificar cánceres que se presentan en las familias. Tenga en cuenta los parientes siguientes:
 Madre/Padre/Hermano/Hermana/Hijos = Parientes de Generación Primera (1st)
 Tía/Tío/Abuelos/Sobrina/Sobrino = Parientes de Generación Segunda (2nd)
 Primos/Bisabuelos/Tía Abuela/Tío Abuelo = Parientes de Generación Tercera (3rd)
 Alguna vez se ha hecho usted o alguno de sus familiares una prueba para detectar su riesgo de cáncer hereditario (BRCA/Colaris)?
 Sí NO

CÁNCER DE COLON Y DE ÚTERO/ENDOMETRIO **(Síndrome de Lynch / Colaris)**

USTED

SU RELACIÓN CON EL PARIENTE
CON CÁNCER

EDAD AL
MOMENTO
DEL
DIAGNÓSTICO

POR PARTE DE SU
MADRE

POR PARTE DE SU
PADRE

☒	☐	EJEMPLO: Dos o más parientes con cáncer de colon o de útero (endometrio), uno antes de los 50 años			Tía-colon	47 años
☐	☐	¿Usted ha tenido cáncer de útero (endometrio) o cáncer de colon, antes de los 50 años?			Hermana-útero	60 años
☐	☐	Dos o más parientes (del mismo lado de la familia) de cualquiera de los siguientes tipos de cáncer, uno antes de los 50 años: (por favor marque con un círculo): colon/colorrectal, ovario, útero/endometrio, estómago, riñón/vías urinarias, cerebro y/o intestino delgado				
☐	☐	Tres o más parientes (del mismo lado de la familia) de cualquiera de los siguientes tipos de cáncer, a cualquier edad. (por favor marque con un círculo): colon/colorrectal, ovario, útero/endometrio, estómago, riñón/vías urinarias, cerebro y/o intestino Delgado				
☐	☐	¿Existe una mutación conocida del Síndrome de Lynch en su familia?				

CÁNCER DE MAMA Y DE OVARIO **(HBOC/BRCAAnalysis)**

USTED

SU RELACIÓN CON EL PARIENTE
CON CÁNCER

EDAD AL
MOMENTO
DEL
DIAGNÓSTICO

POR PARTE DE SU
MADRE

POR PARTE DE SU
PADRE

☐	☐	Cáncer de mama a la edad de 45 años, o menos (Usted mismo, o familia de Primera o Segunda Generación)				
☐	☐	Cáncer de ovario a cualquier edad (Usted mismo, o familia de Primera o Segunda Generación)				
☐	☐	Dos parientes (del mismo lado de la familia) con cáncer de mama, uno antes de los 50 años				
☐	☐	Tres parientes (del mismo lado de la familia) con cáncer de mama, a cualquier edad				
☐	☐	Cáncer de mama en ambas mamas o múltiples tumores malignos primarios de mama				
☐	☐	Cáncer de mama en hombres				
☐	☐	Judía Asquenazí linaje, también con cáncer de mama, de ovario, o cáncer de páncreas, (en la misma persona o del mismo lado de la familia)				
☐	☐	Cáncer de páncreas, también con cáncer de mama o cáncer de ovario, (en la misma persona o del mismo lado de la familia)				
☐	☐	Cáncer de mama del tipo "Triple Negative", antes de los 60 años (ER, PR and Her2 negative receptor status)				
☐	☐	¿Existe una mutación conocida de "BRCA" en su familia?				

Existen otros tipos de cáncer en su familia? (indique el tipo de cáncer, cual pariente y la edad al momento del diagnóstico):

Firma del Paciente: _____ Fecha: _____

FOR OFFICE USE ONLY

☐ Patient is appropriate for further risk assessment and/or genetic testing.
☐ Information given to patient for review. Follow-up appointment scheduled on: _____
☐ Patient offered genetic testing. Accepted ☐ OR ☐ Declined. HGP Signature: _____