PATIENT INFORMATION FORM

PHARMACY # ______________________ DOCTOR/MIDWIFE ______________________

PRIMARY CARE DOCTOR ______________ PRIMARY CARE DOC. PH# __________ FAX# __________

NAME ______________________ SEX ☐ M ☐ F

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)

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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 field 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 ______________

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

Patient: ____________________ Date: ____________________

Medications: ____
____

Allergies: ____

Last Menstrual Period: __________ Cycle Frequency: __________ Duration: __________

Flow: __________

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?	___	
Other		

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		

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		

General Questions

Safe Sex	Y	N
Sexually Active	Y	N
If so, # of partners	______	
STD History	Y	N
Smoking	Y	N
Alcohol	Y	N
If so, how much	______	

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: ____________________

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

Barbara Peluso, C.N.M., A.R.N.P.
Monica Jordan, C.N.M., A.R.N.P.

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 by 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 judgment 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 ne 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 witness(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)

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

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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.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the notice may be changed at anytime. I may obtain a revised copy of the notice by calling (954)431-1211 or by requesting one while at your office.

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

______________________________ ______________________________
Name Relationship to Patient

______________________________ ______________________________
Name Relationship to Patient

______________________________ ______________________________
Patient Name Date Signature of Patient

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601 N Flamingo Road, Suite 205 • Pembroke Pines, FL 33028 • Phone (954)431-1211 Fax (954)431-9298

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.
Barbara Peluso, C.N.M., A.R.N.P.
Monica Jordan, C.N.M., A.R.N.P.

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

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: ____________

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

Patient Name: ______________________ Physician: ______________________

Date of Birth: ______________________ 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	*EXAMPLE: Two or more relatives with a Lynch syndrome cancer; one under age 50*			*Aunt-colon* *Sister-uterine*	*47 yrs* *60 yrs*
Y	N	Have **YOU** been diagnosed with uterine (endometrial) or colorectal cancer before age 50				
Y	N	**TWO** or more relatives on the same side of the family w/ any of the following, one diagnosed before 50 (**please circle**): *colon, uterine/endometrial, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter and renal pelvis*				
Y	N	**THREE** or more relatives on the same side of the family w/ any of the following diagnosed at any age (**please circle**): *colon, uterine/endometrial, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter and renal pelvis*				
Y	N	Family member has a known Lynch syndrome mutation				

		BREAST AND OVARIAN CANCER (HBOC/BRACAnalysis)	**SELF**	**YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER**		**AGE AT DIAGNOSIS**
				MOTHER'S SIDE	**FATHER'S SIDE**	
Y	N	Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	N	Ovarian cancer at any age (in self, first or second degree family members)				
Y	N	**TWO** relatives on the same side of the family with breast cancer—with one under the age of 50				
Y	N	**THREE** relatives on the same side of the family with breast cancer at any age				
Y	N	Multiple breast cancers in the same person (in the same breast or in both breasts)				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family				
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family				
Y	N	Triple Negative breast cancer under age 60 (ER, PR and Her2 negative receptor status)				
Y	N	A family member with a known BRCA mutation				

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 HCP Signature: ______________________