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 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 _____

(Patient's parent, if minor)

QW100

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

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 WOMENS 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)

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.,
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Dear Patients:

In order to give you the best prenatal and or genetic care and advice, please fill out the following questionnaire. These questions about family health apply to members in both your family and in the baby's father's family. If you do not understand some of the questions, please mark them and ask the nurse / physician when she interviews you. Please circle YES or NO to each question.

1) Will you be 35 years old, or older at the estimated delivery date? No Yes

2) Have you or any member of your family or baby's father's family ever been diagnosed as having a genetically inheritable disorder (i.e. muscular dystrophy, cystic fibrosis, hemophilia, Tay Sachs disease, or other metabolic defects)? No Yes

3) Have you or any member of your family or baby's father's family been Diagnosed as having a chromosomal disorder (Downs Syndrome or others)? No Yes

4) If answer to any of the above is yes, please supply details. _____

5) Is there any history of mental retardation in either your family or the baby's father's family? No Yes

6) Have you or the baby's father ever had in this or previous relationships three or more miscarriages? No Yes

7) Have you or the baby's father ever had surgery to correct a birth defect? No Yes

8) Have you or any member in your family or baby's father's family ever had any structural birth defects (i.e. neural tube defect, Spina Bifida, Meningomyelocele, anencephaly, hydrocephaly, congenital heath defect, pyloric stenosis, etc.)? No Yes

9) If the answer to any of the above questions is yes, please give details. _____

PLEASE CONTINUE TO COMPLETE BACK OF FORM

10) Are you or your baby's father of Jewish ancestry? No Yes
If yes, have you been screened for Tay Sachs disease? No Yes
If so, please indicate results _____

11) Are you or the baby's father African American? No Yes
If yes, have either of you been tested for the sickle cell trait? No Yes
If so, please indicate results_____

12) Are you or the baby's father of Italian, Greek, or other Mediterranean descent? No Yes
If yes, have either of you been tested for Beta-thalassemia (Mediterranean or Cooley's anemia)? No Yes
If so, please indicate results_____

13) Are you or the baby's father of Philippine or Southeast Asian ancestry? No Yes
If yes, have either of you been tested for alpha-thalassemia? No Yes
If so, please indicate results_____

14) Have you used any medications (prescription or non-prescription) during the early part of your pregnancy? If yes, please list the medications No Yes

_____

15) Have you consumed moderate or large amounts of alcohol during pregnancy? No Yes

16) Have you consumed any recreational (street drugs) substances at anytime during your pregnancy (crack, marijuana, cocaine, heroin, PCP, amphetamines, methadone, barbiturates, or others)? No Yes

17) Have you received X-rays during your pregnancy? No Yes

18) Now or in previous relationships, have you or your baby's father ever had a Still born child or early neonatal death of uncertain cause? No Yes

This genetic screening aid is not intended as a substitute for genetic counseling. Furthermore, the use of this screening is an aid and cannot guarantee the absence of genetic disease, mental retardation, or birth defects to one's offspring.

Signature: _____

Date: _____

Help your baby have a healthy start in life!

Please answer the following questions to find out if anything in your life could affect your health or your baby's health. Your answers are confidential. You may qualify for free services from the Healthy Start Program or the Healthy Families Program, no matter what your income level is! (Please complete in ink.)*

Today's Date: _____

	YES	NO
1. Have you graduated from high school or received a GED?		1
2. Are you married now?		1
3. Are there any children at home younger than 5 years old?		
4. Are there any children at home with medical or special needs?		
5. Is this a good time for you to be pregnant?		
6. In the last month, have you felt down, depressed or hopeless?	1	
7. In the last month, have you felt alone when facing problems?		
8. Have you ever received mental health services or counseling?		
9. In the last year, has someone you know tried to hurt you or threaten you?		
10. Do you have trouble paying your bills?		

11. What race are you? Check one or more.
☐ White ☐3 Black ☐ Other _____

12. In the last month, how many alcoholic drinks did you have per week?
_____ drinks1 ☐ did not drink

13. In the last month, how many cigarettes did you smoke a day? *(a pack has 20 cigarettes)*
_____ cigarettes1 ☐ did not smoke

14. Thinking back to just before you got pregnant, did you want to be.....?
☐ pregnant now ☐ pregnant later ☐1 not pregnant

15. Is this your first pregnancy?
☐2 Yes ☐ No If no, give date your last pregnancy ended:
Date: (month/year)_____

16. Please mark any of the following that have happened.
☐3 Had a baby that was not born alive
☐3 Had a baby born 3 weeks or more before due date
☐3 Had a baby that weighed less than 5 pounds, 8 ounces
☐ None of the above

PATIENT INFORMATION

Name: First Last M.I.	Social Security Number:	Date of Birth (mo/day/yr):	17. Age: ☐1 <18
Street address (apartment complex name/number):	County:	City: State:	Zip Code:
Prenatal Care covered by: ☐ Medicaid ☐ Private Insurance _____ ☐ No Insurance ☐ Other _____	Best time to contact me:	Phone #1 _____ Phone #2 _____	

I authorize the exchange of my health information between the Healthy Start Program, Healthy Start Providers, Healthy Start Coalitions, Healthy Families Florida, WIC, Florida Department of Health, and my health care providers for the purposes of providing services, paying for services, improving quality of services or program eligibility. This authorization remains in effect until revoked in writing by me.

Patient Signature: _____ **Date:** _____

Please initial: _____ Yes _____ No I also authorize specific health information to be exchanged as described above, which includes any of my mental health, TB, alcohol/drug abuse, STD, or HIV/AIDS information.

** If you do not want to participate in the screening process, please complete the patient information section only and sign below:*

Signature: _____ *Date:* _____

PROVIDER ONLY

LMP (mo/day/yr):	EDD (mo/day/yr):	18. Pre-Pregnancy: Wt: _____lbs. Height: _____ft. _____in. BMI: _____	☐1 < 19.8 ☐2 > 35.0
Provider's Name:	Provider's ID:	19. Pregnancy Interval Less Than 18 Months? ☐ N/A ☐ No	☐1 Yes
		20. Trimester at 1st Prenatal Visit? _____	☐1 2nd
Provider's Phone Number:	Provider's County:	21. Does patient have an illness that requires ongoing medical care? Specify illness: _____ ☐ No	☐2 Yes
Healthy Start Screening Score:	Check One: ☐ Referred to Healthy Start. If score <6, specify: _____ ☐ Not Referred to Healthy Start		