Florida Urogynecology & Reconstructive Pelvic Surgery, P.A.

Patient Name (Please Print): _____

Street Address: _____ SSN: _____

City/State: _____ Zip Code: _____ DOB: _____

Race: _____

Male/Female: _____ Marital Status: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Employer: _____

Email: _____

Spouse or Parent Information

Name: _____ SSN: _____

DOB: _____ Employer: _____

Home Phone: _____ Business Phone: _____

Relationship to Patient: _____

Note: All charges are due at the time of service. Copies of insurance cards and appropriate referral information must be received prior to physician contact.

Insurance Information

Primary Insurance: _____ Group #: _____

Insurance ID Number: _____ Policy Holder: _____

Effective Date of Coverage: _____ **PRESENT CARD TO STAFF**

Secondary Insurance: _____ Group #: _____

Insurance ID Number: _____ Policy Holder: _____

Effective Date of Coverage: _____ **PRESENT CARD TO STAFF**

Emergency Contact: _____ Phone: _____

I hereby certify that the above information given by me in applying for payment of medical services is accurate. In addition, I request that payment of authorized Medicare/Other insurance company benefits be made on my behalf to Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. for any services furnished to me by that party who accepts assignments. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits to Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.
Florida Urogynecology & Reconstructive Pelvic Surgery, P.A.

Patient Name: _____

Privacy Notice Acknowledgement

I acknowledge that I have had the opportunity to receive a copy of Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. Privacy notice dated September 7, 2004. I understand that I am responsible to read this Notice and notify Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. in writing, of any request for restrictions on the use or disclosure of my individually identifiable health information. Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. has the right to revise this Notice at anytime and will post a copy of the current notice in the office in a visible location at all times and on their website at www.flurogyn.com. Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. will provide me with a copy of its most recent Notice upon my request.

Financial Responsibility

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. I am responsible for any applicable deductible or co-payments prior to the provision of services. I understand that by law, deductible, co-payment, and co-insurance cannot be waived. For surgery, Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment and/ or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. I further understand that such payment is not contingent on the results of any treatment. Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. does not refund any payment for services rendered.

Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. may file a claim for payment with my insurance company as required by contractual agreement. I understand that if my insurance company sends me a check for payment of the services provided by Florida Urogynecology & Reconstructive Pelvic Surgery, P.A., the check belongs to Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. and I must immediately deliver the check to Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. for payment on my account. If the insurance company fails to pay Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. in a timely manner I understand that I will be responsible for prompt payment of all amounts owed to Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. I understand that I am financially responsible for all amounts not covered by my insurance company. Should the account be referred to a collection agency or attorney for collections, the undersigned shall pay all cost of collection, including reasonable attorney's fee.

Additional Information

Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. accepts payment in cash, check and credit cards. There is a $25.00 fee for returned checks. This fee is in addition to any fees that may be assessed by my bank for returned checks. In the event that I pay by credit card, I understand that the credit card must not have expired and not reached its available credit limit.

In the event that I receive a payment from my insurance carrier, I agree to endorse any payment due for services rendered to Florida Urogynecology & Reconstructive Pelvic Surgery, P.A.

Consent for Treatment

I give my consent to Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. to provide medical care, diagnostic testing and treatment deemed medically necessary and proper in diagnosing or treating my medical condition. In the event that my condition requires a procedure or surgery, I understand that I will execute a specific informed consent for such procedure or surgery.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

_____ _____

Signature Date

New Patient Information

Patient Name: _____ AGE _____

Height: _____ Weight: _____ Primary Care Doctor/Telephone #:_____

Referring Physician/Telephone #: _____

Pharmacy Name/Telephone # :_____

Prescription Insurance Plan & ID #: _____

Reason for Visit:

_____

_____

Is this visit due to a work related injury or an automobile accident: _____

Current Medical Problems: (Please circle all)

Arthritis	Y N	High Blood Pressure	Y N
Asthma	Y N	High Cholesteral	Y N
Blood Clots	Y N	Irritable Bowel Syndrome	Y N
Bronchitis	Y N	Kidney Disease or Stones	Y N
Cancer	Y N	Mitral Valve Prolapse	Y N
COPD/Emphysema	Y N	Reflux	Y N
Diabetes	Y N	Thyroid Disorder	Y N
Glaucoma	Y N (open / closed)	Ulcers	Y N
Heart Disease	Y N		

Other :_____

OB/GYN History:

Number of Pregnancies: _____ Number of Live Births: _____ Number of C-Sections: _____

Last Mammogram: _____(Normal / Abnormal) Last Pap Smear: _____(Normal / Abnormal)_

Last Menstrual Cycle: _____(Regular / Irregular) Menstrual Problems: Y N

Age at Onset of Menstrual Cycle: _____ Sexually Active: Y N

Menopause Since: _____

Surgical History:

Hysterectomy: Y N Date: _____ If yes, please circle whether it was **Abdominal**, **Laparoscopic**, or **Vaginal**. **Ovaries Removed**: No / RT / LT / Both

Bladder Repair: Y N Date: _____ Type: _____

Surgeon:_____ Where:_____

Other Surgeries Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Medication Drug Allergies & Reaction: (Please list)

_____

_____

_____

Current Medications – including Over the Counter Medications and Vitamins:

Name:	Dose/How Often:	Why are you taking this medication?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: (Please circle all)

Breast Cancer	Y N	Hypertension	Y N
Colon Cancer	Y N	Ovarian Cancer	Y N
Diabetes	Y N	High Cholesterol	Y N
Heart Disease	Y N	Stroke	Y N

Others not listed above:_____

_____

Social History: (Please check all that apply)

Marital Status: □ Single □ Married □ Divorced □ Widowed

Alcohol: □ Never □ Rarely □ Moderate □ Daily

Tobacco Use: □ Never □ Currently Smoke _____Pack/Day for _____Years

□ Stopped in _____

Caffeine Use: □ None □ 1-2 Cups/Day □ 4-6 Cups/Day □ More Than 6 Cups/Day

Drug Use: □ Never □ Yes, Type: _____

Living Will: Y N

Review of Systems: (Please circle all)

Constitutional:		Musculoskeletal:	
Recent weight change	Y N	Joint pain	Y N
Fever	Y N	Muscle pain	Y N
Fatigue	Y N	Back pain	Y N
		Stiffness	Y N
Eyes/Ears/Nose/Throat:		**Integumentary:**	
Hearing loss/ringing	Y N	Rash/itching	Y N
Chronic sinus problems	Y N	Breast pain/lump	Y N
Sore throat	Y N	Varicose veins	Y N
Cardiovascular:		**Neurological:**	
Chest pain	Y N	Headaches	Y N
Ankle swelling	Y N	Dizziness	Y N
Irregular heart beat	Y N	Convulsions	Y N
Waking up short of breath	Y N	Paralysis/Numbness	Y N
		If Yes where: _____	
Respiratory:		**Psychiatric:**	
Chronic cough	Y N	Memory loss	Y N
Short of breath with activity	Y N	Depression	Y N
Sleeping on more than 1 pillow	Y N		
Gastrointestinal:		**Endocrine:**	
Nausea/vomiting	Y N	Heat Intolerance	Y N
Frequent diarrhea	Y N	Cold Intolerance	Y N
Bloody/painful bowel movements	Y N	Excessive Thirst	Y N
		Glandular/Hormone problem	Y N
Genitourinary:		**Hematological:**	
Vaginal discharge	Y N	Anemia	Y N
Visible Blood in urine	Y N	Past transfusion	Y N
Recurrent Bladder infections	Y N	Free Bleeder	Y N
Kidney Stones	Y N		
Kidney Failure	Y N		

Other:

_____

_____

_____

_____