Patient Demographics

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PATIENT'S INFORMATION

NAME IN FULL				AGE	TODAY'S DATE
EMAIL ADDRESS			SSN	DATE OF BIRTH	ETHNICITY
ADDRESS			CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER		
REFERRED BY			THIS FORM IS BEING COMPLETED BY	RELATIONSHIP	

PARENT/GUARDIAN INFORMATION (if patient is a minor)

MOTHER'S NAME IN FULL			AGE	DATE OF BIRTH	ETHNICITY
FATHER'S NAME IN FULL			AGE	DATE OF BIRTH	ETHNICITY
ADDRESS			CITY	STATE	ZIP CODE
HOME PHONE	MOTHER'S CELL PHONE	MOTHER'S WORK PHONE	FATHER'S CELL PHONE	FATHER'S WORK PHONE	MOTHER'S SSN
MOTHER'S EMPLOYER		FATHER'S EMPLOYER			FATHER'S SSN

EMERGENCY CONTACTS

NAME	RELATIONSHIP TO PATIENT	HOME PHONE	CELL PHONE	WORK PHONE
NAME	RELATIONSHIP TO PATIENT	HOME PHONE	CELL PHONE	WORK PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	POLICYHOLDER'S NAME	DATE OF BIRTH	POLICY NUMBER	GROUP NUMBER
SECONDARY INSURANCE COMPANY	POLICYHOLDER'S NAME	DATE OF BIRTH	POLICY NUMBER	GROUP NUMBER

MEDICAL CONTACTS

PRIMARY CARE PHYSICIAN	SPECIALTY	PHONE NUMBER	FAX NUMBER

Payment is expected at the time of service unless arrangements are made prior to appointment time. We accept Visa, MasterCard, Debit Cards, Checks, and Cash.
I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE THIS INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION, HEALTH CARE FINANCING ADMINISTRATION, MY INSURANCE COMPANY OR ITS INTERMEDIARIES OR CARRIERS, OR TO THIS PHYSICIAN'S OFFICE OR TO MY ATTORNEY OR OTHER DOCTOR'S OFFICE.
I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE, AND ANY OTHER HEALTH PLAN TO THE ABOVE NAMED PHYSICIAN(S).
I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

Patient /Guardian Signature

Witness Signature

Date

Patient Guardian Name (printed)

Witness Name (printed)

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

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NAME ______________________________

BIRTHDATE ______________________ SOCIAL SECURITY # ______________________

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually performed.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professions

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already

Office use only:

❑ Accepted
❑ Denied

Signature	Title	Date

❑ **I request the following restrictions to the use or disclosure of my healthcare information:**

____
____
____
____
____
____

❑ No restrictions

Patient Signature	Witness Signature	Date
Patient Name (printed)	Witness Name (printed)	

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New Patient Intake

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Medical and Family History

	Self Yes	Self No	Family Yes		Self Yes	Self No	Family Yes
1 WT LOSS-GAIN	❑	❑	❑	16 URINARY INCONTINENCE	❑	❑	❑
2 HEADACHES / MIGRAINE	❑	❑	❑	17 URINARY INFECTIONS	❑	❑	❑
3 HEART DISEASE	❑	❑	❑	18 BLOOD TRANSFUSIONS	❑	❑	❑
4 VALVULAR DISEASE	❑	❑	❑	19 ANEMIA / BLOOD DISORDER	❑	❑	❑
5 RHEUMATIC DISEASE	❑	❑	❑	20 BLEEDS EASILY	❑	❑	❑
6 LUPUS	❑	❑	❑	21 VARICOSE VEINS / PHLEBITIS	❑	❑	❑
7 HIGH BLOOD PRESSURE	❑	❑	❑	22 SKIN DISEASE	❑	❑	❑
8 HIGH CHOLESTEROL	❑	❑	❑	23 DIABETES	❑	❑	❑
9 RESPIRATORY/PULMONARY/LUNG DISEASE	❑	❑	❑	24 THYROID DISEASE	❑	❑	❑
10 BREAST DISEASE	❑	❑	❑	25 CANCER (TYPE)	❑	❑	❑
11 JAUNDICE / HEPATITIS	❑	❑	❑	26 EPILEPSY / NEUROLOGICAL	❑	❑	❑
12 HIATAL HERNIA (REFLUX)	❑	❑	❑	27 ARTHRITIS - JOINT PAIN	❑	❑	❑
13 PEPTIC ULCER (STOMACH)	❑	❑	❑	28 OSTEOPOROSIS (FRAGILE BONES)	❑	❑	❑
14 BOWEL DISEASE	❑	❑	❑	29 ANXIETY / DEPRESSION	❑	❑	❑
15 KIDNEY DISEASE	❑	❑	❑	30 SLEEP PROBLEMS	❑	❑	

Did your mother take DES or any hormones when she was pregnant with you? ❑ Yes ❑ No ❑ Don't know

Please provide details for all significant prior medical illnesses and current medical problems for which you are under medical treatment:

SURGICAL HISTORY

Please list all surgical procedures you have had and the year they were performed:

Year	Procedure

MEDICATIONS

Please list all current medications:

Medication	Dosage	Frequency	Use

ALLERGIES

Please list all medication allergies:

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Gynecological History

Age at first period | When was your last period? | When was the period before that?

How far apart are your cycles? | How many days do they last?

Circle any symptoms associated with your period: cramps | heavy flow/clots | headaches | breast tenderness | change in mood | pelvic pain

Circle your current forms of birth control: none | natural family planning | tubal ligation | spermicide | diaphram | IUD | norplant | depoprovera injections | birth control pills | vasectomy | condoms

Sexual preference (circle one): heterosexual | lesbian | bisexual

Have you ever had an abnormal pap smear? ❑Yes ❑No
- if yes, list any treatments

Do you desire pregnancy at this time? ❑Yes ❑No
Do you examine your breasts every month? ❑Yes ❑No

Do you have pain with intercourse? ❑Yes ❑No
Do you have bleeding after intercourse? ❑Yes ❑No

Do you use douches? ❑Yes ❑No
Have you stopped having periods? ❑Yes ❑No

Have you ever been sexually involved with another person? ❑Yes ❑No
- if yes, age at your first encounter: ______
Number of sexual partners in the last 12 months: ______
Number of lifetime sexual partners: ______
Are you currently sexually active? ❑Yes ❑No

Have you ever had a sexually transmitted disease? ❑Yes ❑No
- if yes, which ones: gonorrhea | herpes | PID | hepatitis B | trichomonas | chlamydia | syphilis | HIV | genital warts

Have you ever had any other vaginal infections? ❑Yes ❑No
- if yes, which ones: bacterial vaginosis | yeast | other: ________________

Obstetrical History

Please list all pregnancies you have had including miscarriages, abortions, and ectopic pregnancies

Year	Vaginal or Caesarian	Length of Labor	Length of Pregnancy	Anesthesia	Sex	Birth Weight	Maternal Weight Gain	Complications

Social History

❑Yes ❑No Do you smoke cigarettes? If so, how many cigarettes per day? ______ For how many years? ______
❑Yes ❑No Do you drink alcohol? If so, how many drinks per week? ______ For how many years? ______
❑Yes ❑No Do you use drugs? If so, which ones? ______ For how many years? ______
❑Yes ❑No Do you use seatbelts? ❑Yes ❑No Do you exercise?
❑Yes ❑No Have you ever received a blood transfusion? ❑Yes ❑No Are you under a lot of stress?
Place of birth: ________________ If you were not born in this country, how many years have you lived here? ________

Planning Questionaire

❑Yes ❑No Do you have a durable power of attorney?
❑Yes ❑No Have you made a living will?

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New Patient Intake

Immunizations

Tetanus Booster	Date: ________________	**Influenza Vaccine**	Date: ________________
Rubella Vaccine	Date: ________________	**Pneumococcal Vaccine**	Date: ________________
Hepatitis B Vaccine	Date: ________________	**Varicella Vaccine**	Date: ________________

Present Symptoms (circle any that apply)

General/Constitutional	Weight loss	Weight gain	Fever	Night sweats
Eyes	Double vision	Tearing	Blind spots	Eye pain
Ears/Nose Mouth/Throat	Headaches	Dizziness	Lightheadedness	Nose bleeding
	Nasal obstruction	Dental difficulties	Bleeding gums	Dentures
	Neck stiffness	Neck pain	Neck tenderness	Neck mass
Cardiovascular	Chest pain	Irregular heart beat	Shortness of breath with exertion	
	Fainting	Swelling	Shortness of breath when waking at night	
	High blood pressure	Heart murmur	Shortness of breath lying down	
	Varicosities	Phlebitis	Painful extremity with movement	
Respiratory	Wheezing	Cough	Coughing blood	Respiratory infections
	Tuberculosis			
Gastrointestinal	Poor appetite	Difficulty swallowing	Indigestion	Abdominal pain
	Heartburn	Burping	Nausea	Vomiting
	Vomiting blood	Yellow skin	Constipation	Diarrhea
	Abnormal stools	Flatulence	Hemorrhoids	Recent changes in bowel habits
Genitourinary	Urinary urgency	Frequent urination	Lack of urine	Getting up at night to urinate
	Blood in urine	Urinary infections	Nephritis	Vaginal discharge
	Urinary incontinence	Painful urination	Stones	Venereal disease
Musculoskeletal	Joint pain	Limitation of motion	Muscular weakness	Muscle cramps
Skin/Breast	Rash	Itching	Pigmentation	Changes in hair growth or loss
	Nail changes	Breast lumps	Breast tenderness	Breast swelling
	Nipple discharge			
Neurologic	Convulsions	Paralysis	Difficulties with memory or speech	
	Tremor	Incoordination	Sensory or motor disturbances	
			Problem with muscular coordination	
Psychiatric	Nervousness	Emotional problems	Anxiety	Previous psychiatric care
	Hallucinations	Depression		
Endocrine	Hormone therapy	Abnormal growth	Increased water intake	
	Bleeding tendency	Anemia	Intolerance to heat or cold	
			Previous transfusions and reactions (eg. Rh incompatibility)	
Hematology/Lymphatic	Lymph node enlargement or tenderness			
Allergic/Immunologic	Reactions to drugs	Reaction to food	Reaction to insects	

❑ Check here if none of the above symptoms apply

Bladder Health Questionnaire

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FULL NAME	TODAY'S DATE

1. How many times do you urinate in 1 day? ______
2. How many times do you get up to urinate at night? ______
3. Do you ever leak urine when you cough, sneeze, laugh, or during athletic activities? ☐ YES ☐ NO
4. Do you usually have a strong sense of urgency to urinate? ☐ YES ☐ NO
5. Do you have difficulty starting your urine stream? ☐ YES ☐ NO
6. Have you been treated for a urinary infection? ☐ YES ☐ NO
   - How many? ______
   - How recent? ______
7. Have you ever leaked urine because you could not make it to the bathroom in time? ☐ YES ☐ NO
8. Does the loss of urine or overactive bladder affect your quality of life? ☐ YES ☐ NO

Have your bladder symptoms …

9. Caused you to plan "escape routes" to restrooms in public places? ☐ YES ☐ NO
10. Made you avoid activities away from restrooms (walks, running, biking, etc.)? ☐ YES ☐ NO

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Dear Patient:

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical 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 noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Regretfully, the practice has made the decision of being uninsured because the malpractice insurance premiums have become too expensive and we simply cannot afford this coverage any longer.

If the action that this practice has taken makes you uncomfortable in initiating or continuing in your care, it is suggested that you search for an insured physician within your community.

This document **MUST** be signed before you initiate or continue under the care of the practice.

Thank you,

Sara J. Bernstein, M.D.

I have read this document and acknowledge and understand its contents.

Patient/Guardian Signature	Patient/Guardian Name (printed	Date
Witness Signature)	Witness Name (printed)	Date

Credit Card On File Authorization

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As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and held securely and then later used to pay your bill.

Here at The Women's Health Institute, we have implemented a similar financial policy. You will be asked to verify you on-file credit card information each time you make an appointment and the information will be held securely. Your credit card will not be charged for a service covered under your active medical insurance policy, with the exception of co-pays, deductibles and non-covered services.

If your insurance carrier(s), after processing your claim, determines that you are responsible for any portion of the charge or you incur a charge due to a late cancellation, missed appointment, returned check, or any other reason; your credit card will then be charged. We will notify you by mail sending you a confirmation of the charge along with a statement explaining the reason for your remaining balance.

This policy will be an advantage to you, since you no longer have to write out and mail us a check. It will be an advantage to us as well, as it will greatly decrease the number of statements that we generate and send out. The combination will benefit everyone in helping to keep the cost of health care down. This policy in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

If you have a co-pay or deductible as part of your insurance policy, that amount will still need to be paid by you at the time of your visit provided this information is available to the practice at the time that you check in.

If you have any questions regard this payment policy, please ask to speak with the office manager.

By signing below, I authorize The Women's Health Institute to charge my account balance using the card number I have provided for the Credit/Debit Card payment transactions.

Patient / Legal Guardian Signature	Print Name and Relation to Patient	Date