Manatee Gynecology

New Patient Paperwork

P: 941-792-4993 | F: 941-795-2905

Patient Name (Last, First, M.I., Maiden): _____Date of Birth: _____

Current Medications / Supplements / Creams

Please list all medications, hormones, birth control pills, contraceptive implants (i.e. Nexplanon/IUD), herbal/OTC supplements, and all creams:

Medication Name	Dose	Route	Frequency	Start Date	Indication

Personal Medical History

Please indicate if you have/had any of the following medical conditions:

☐ Breast Cancer	☐ Endometriosis	☐ Osteopenia	☐ Migraine (WITH Aura)
☐ Ovarian Cancer	☐ Hypertonic Pelvic Floor	☐ Osteoporosis	☐ Migraine (w/o Aura)
☐ Uterine Cancer	☐ Hypothyroidism	☐ Blood Clot (DVT)/PE	☐ Anxiety
☐ Cervical Cancer	☐ Hyperthyroidism	☐ Clotting Disorder (i.e. Factor V Leiden)	☐ Depression
☐ Colon Cancer	☐ Heart Attack	☐ Bleeding Disorder (i.e. Von Willebrand)	☐ Bipolar Disorder
☐ Other Cancer:	☐ Stroke	☐ Anemia	☐ ADD/ADHD
☐ Fibroids	☐ Diabetes	☐ Blood Transfusion	☐ Vitamin D Deficiency
☐ Ovarian Cyst	☐ High Blood Pressure	☐ GERD (Reflux)	☐ Obesity
☐ PCOS	☐ High Cholesterol	☐ Infertility	☐ Other:

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Allergies

List all allergies to medications, latex, foods, and X Ray dyes:

Allergen	Reaction

Surgical History / Hospitalizations

List all surgeries, procedures, and hospitalizations (Including Colonoscopies):

Surgery / Procedure / Hospitalization	Reason	Year

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Family History:

Please indicate below as applicable and state age of onset if related to cancer:

☐ **If adopted or history is unknown, please check this box.**

	Breast Cancer	Ovarian Cancer	Uterine Cancer	Colon Cancer	Osteo-porosis	Bleeding Disorder	Clotting Disorder	Thyroid Disease	Heart Disease	Stroke	Diabetes	High Blood Pressure
Father												
Mother												
Paternal GF												
Paternal GM												
Maternal GF												
Maternal GM												
Brother (s)												
Sister (s)												
Paternal Uncle												
Paternal Aunt												
First Cousin (P)												
Maternal Aunt												
Maternal Uncle												
First Cousin (M)												
Son(s)												
Daughter (s)												
Other												

☐ **Please list any known genetic syndromes or mutations and associated relative (i.e. Lynch Syndrome, BRCA 1 / 2, CHEK2, MUTYH):**

_____

Social History:

Please circle:

Do you Smoke? Yes How Much? _____ No Never Former Quit in (year): _____

Do you Drink Alcohol? No Yes How Much? (# of Drinks) _____ Daily Weekly Monthly Rarely

Do you use Illicit Drugs? No Yes What Substance? _____

Do you Drink Caffeine? No Yes How many cups per day? _____

Do you Exercise? No Yes What do you do? _____ How Often? _____

Marital Status Single Married Divorced Widowed

Occupation Currently Working Job: _____ Retired Retired From What Job: _____

Do you wear a seatbelt? Yes No

Patient Name (Last, First, M.I., Maiden): _____Date of Birth: _____

Gynecological History:

Please fill out in its entirety to the best of your knowledge:

Last Mammogram Date:_____ Results: _____ Where was it performed?_____

History of Abnormal Mammogram? No Yes If yes, what was the workup? Breast US MRI Biopsy Surgical Referral

Last Colonoscopy/Cologuard Date:_____ Results: _____ When should you return? Every 3 5 7 10 Years

Last Bone Density Date: _____ Results: Normal Osteopenia Osteoporosis

Last Pelvic Ultrasound Date: _____ Reason for Ultrasound: _____ Result: _____

Last Pap Smear Date: _____ Results: _____ Where was your last pap done? _____

Last HPV Test Date: _____ Results: Positive Negative

Have you ever had an abnormal pap smear? No Yes If yes, did you have a procedure or biopsy? Yes No

Have you had the HPV Vaccine (Gardasil)? No Yes If yes, did you complete the series? No Yes

Did you have sex before age 16? Yes No

Have you had 5 or more lifetime sexual partners? Yes No

Have you had fewer than 3 negative pap smears in the last 7 years? Yes No

Were you been exposed to DES (Diethylstilbestrol) while in utero? (Given to prevent miscarriage between 1940-1971) Yes No

Are you sexually active? No Yes Same partner since what year? _____

Do you have a history of sexual abuse? Yes No

Gender of your partner? _____ Have you had a new sexual partner within the last year? Yes No

What is your current method of contraception (birth control)?

None Abstinence Withdrawal Rhythm Diaphragm Condoms

Pills Patch Ring Injection Nexplanon IUD - Hormonal Paragard IUD

Essure Tubal Ligation Partner Vasectomy Hysterectomy Menopause

Please note any birth control methods that you did not tolerate: _____

If you've had a hysterectomy, what was it for? _____

Have you ever had a sexually transmitted infection? No Yes If yes, please list: _____

Please note the age of your first period: _____ Date of Last Menstrual Period: _____

If you are still having periods: What is your Baseline Menstrual Cycle: Regular Irregular They come every #_____ Days

Describe your menstrual flow: Light Moderate Heavy Cramps: With Without

How long do your periods last? # Days _____

Do you have bleeding between your periods? Yes No Do you bleed with intercourse? Yes No

Please indicate, if applicable, your age of menopause: _____

Have you ever used hormone replacement therapy via pill, patch, gel, injection, or pellet? No Yes

If yes, did you use: Estrogen, Progesterone, or Testosterone? Please circle all that apply. Length of Use: _____

If you were taken OFF of hormones, why? _____

Have you ever used vaginal/vulvar estrogen cream? No Yes

The following are contraindications for the use of hormones (i.e. birth control pills, hormone replacement therapy via pill, patch, gel, pellet).

Heart Attack, Stroke, Blood Clot, Blood Clotting Disorder, Migraine with Aura, Ocular Migraines, Known/Suspected/History of Breast Cancer, Smoking

Do you have currently or have had in the past, any of the above listed conditions? No Yes

If yes, please list and explain:

_____

_____

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Obstetrical History:

Please fill out in its entirety to the best of your knowledge:

	Number	Details
Total Pregnancies		
Full Term		**Vaginal / C Section / Forceps / Vacuum**
Pre Term		**Vaginal / C Section / Forceps / Vacuum**
Miscarriage		**D & C**
Elective Termination		**Medical Treatment / Surgical Treatment**
Ectopic		**Right / Left / Medical Treatment / Surgical**
Living Children		
Multiple Gestations		**Twins / Triplets**
Complications		

Other:

Please indicate your preferred (Name, Location, Phone Number):

Pharmacy (Local): _____

Pharmacy (Mail Order): _____

Laboratory: _____

Imaging Center:_____

Please provide the first and last name of your current providers:

Primary Care Physician: _____

Urologist: _____

Gastroenterologist: _____

Dermatologist: _____

Cardiologist: _____

Surgeon: _____

Oncologist: _____

Hematologist: _____

Other (Please Specify): _____

Other (Please Specify): _____

Patient Signature

_____ _____

Signature of Patient/Guardian **Date**

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Patient Information

Failure to disclose accurate information may result in the termination of your relationship with our physicians/office.

_____

Patient Name (Last, First, M.I., Maiden) Date of Birth Social Security Number

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Partner

Race/Ethnicity: ❑ Asian ❑ Black/African ❑ Caucasian ❑ Hispanic/Latino ❑ Native American ❑ Pacific Islander
❑ Prefer Not to Answer ❑ Other:_____

_____

Mailing Address (House Number, Street, City, State, Zip Code)

_____

Home Phone Mobile Phone Work Phone Email

_____

Spouse or Guardian (If Minor)

_____

Emergency Contact Person Relationship Phone

_____ _____

Primary Insurance Company Secondary Insurance Company

_____ _____

Identification Number Identification Number

_____ _____

Policy Holder Policy Holder

_____ _____

Date of Birth Social Security Number Date of Birth Social Security Number

Have you ever applied or been approved for any type of MEDICAID ASSISTANCE? ❑ Yes ❑ No

Who is your referring physician? _____

If you are covered by an HMO/PPO requiring an authorization, it is your responsibility to obtain that authorization prior to your scheduled appointment. If you have any questions about authorizations, call your insurance carrier, member services department, or if applicable, your primary care physician. Depending on the type of service you need, you may be required to make a deposit of payment agreement for the estimated charges prior to being seen. **A service charge of $15.00 will be added to your account if your estimated portion is not collected at the time of service.**

I hereby authorize Manatee gynecology, LLC to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services to myself or dependents. I understand that I am responsible for any amount not covered or authorized by my insurance carrier for all office or surgical charges. Any unpaid balance older than 90 days will be sent to a third-party collection agency and you will be billed a $50.00 service fee.

Please indicate if you have <u>ever</u> seen any of the following providers in the office or in the hospital:

❑ Dr. Marion Pandiscio ❑ Dr. Kinnari Desai ❑ Dr. Lee Biggs ❑ Linda O'Gara, WHNP ❑ Joyce Kepto, CNM, APRN

❑ Sammie Billman, DNP, APRN ❑ Kaleigh Braden, DNP, APRN ❑ Felicia Montanez, APRN

_____ _____

Signature of Patient/Guardian Date

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Authorization for the Use or Disclosure of Health Information

_____

Patient Name (Last, First, M.I., Maiden) Date of Birth

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW",
WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging center, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.
- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on an answering machine mobile voicemail, text, or email.

Which phone number would you like us to use? ❑ Home ❑ Cell ❑ Work

I authorize my healthcare provider to send information to me, by email, text, or through a mail service, about products or services the practice or our sister med spa company, Well Within Skin and Laser Center, may now or in the future provide that may be of interest to me.

Can we release information to anyone other than you? ❑ Yes ❑ No
Please list each person and indicate which permissions are allowed.

Name: _____ ❑ Records ❑ Financials ❑ Appointments
Relation:_____

Name: _____ ❑ Records ❑ Financials ❑ Appointments
Relation:_____

For Patients Under Age 18
Written parental or legal guardian consent is needed to provide any type of medical care or to prescribe medically necessary medication to a minor. In addition to the above information, I authorize Manatee Gynecology, LLC to diagnose, provide medical treatment, and prescribe medications for:

_____

Patient Name Signature of Guardian Date

❑ Please check here if you authorize us to use your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others.

You may request a copy of and you have the right to read our *"Notice of Patient Privacy Practices" (NPP)* prior to signing this authorization The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

_____ _____ *This Document Does Not Expire At Any Time*

Signature of Patient/Guardian Date

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Appointment Policies

_____

Patient Name (Last, First, M.I., Maiden) Date of Birth

Appointments
Late Cancellation / Late Reschedule / No Show Fees

Our office policy is to charge a $25.00 fee to patients who fail to keep their appointment or cancel/reschedule with less than 48 business hours' notice. When patients do not give adequate notice of cancellation, we are not able to use that time for other patients who need to be seen. The fee will be billed to your account and must be paid before any appointments or surgeries will be scheduled. (We offer reminder calls as a courtesy to our patients. If you do not receive a reminder call that does not eliminate your responsibility to show or a scheduled appointment or constitute that the fee will be waived.)

Preventive / Annual Physical Exams

According to the CPT (Code Book) a Preventive Physical Exam is defined as an "Age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction intervention, and the order of laboratory/diagnostic procedures."

If an abnormality is encountered or a problem/pre-existing problems is addressed in the process of performing this preventive medicine evaluation, and if the problem/abnormality is significant to require additional work to perform the key components of a problem-oriented services then the appropriate visit code shall be charged as well.

When you come to the office for your preventive/annual physical exam, if you are healthy and have no continuing medical conditions, then only a preventive code will be charged. If you are insistent on only preventive code being charged, then you will only have the preventive exam and will be asked to return to the office for a second visit to address the problems/conditions that you are having.

We are attempting to provide the most comprehensive care that is possible and must code the visits according to the appropriate level of care provided.

**Please keep in mind, some insurance carriers will not allow any abnormalities or problems to be addressed at a preventive/annual physical exam. Also, if your medical condition requires immediate attention, we will have no choice but address that condition and reschedule your preventive/annual physical exam.

_____ _____

Signature of Patient/Guardian Date