

Manatee Gynecology, LLC

PH. 941-792-4993

FAX. 941-795-2905

Patient Information (Failure to disclose accurate information may result in the termination of your relationship with our physicians/office)

Patient Name (Last, First, MI, 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
 Other _____ Prefer not to answer

Mailing Address (Street, City, State, Zip Code) _____

Home Phone _____ Mobile Phone _____ Work Phone _____ Email _____

Spouse or Guardian (if minor) _____

Emergency Contact Person

Name _____ Relationship _____ Phone _____

Primary Insurance _____

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 or 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 patient 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 ever seen any of the following providers in the office or in the hospital.

- Marion Pandiscio, M.D. Kinnari Desai, M.D. Denniz Zolnoun, M.D. Kavita Khanijow, M.D.
 Rebecca Medlin, A.P.R.N. Ellen Huenink, D.N.P., A.P.R.N. None

Signature of Patient _____

Date _____

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Please indicate if you have any of the following medical conditions.

- | | | | |
|--|--|---|-------------------------------------|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Uterine Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other_____ |

List all surgeries, procedures and hospitalizations

Year	Reason

List all prescription and over-the-counter drugs (including vitamins, supplements, herbs, inhalers)

Medication Name	Dose	Route	Frequency	Start Date	End Date	Indication

List all allergies to medications, latex, foods, and x-ray dyes

Medication	Reaction

Obstetrical History

	Number	Details (SVD, C/S, D&C, Complications)
Total Pregnancies		
Full Term		<input type="checkbox"/> vaginal delivery <input type="checkbox"/> C/S <input type="checkbox"/> forceps/ vacuum
Pre Term		<input type="checkbox"/> vaginal delivery <input type="checkbox"/> C/S <input type="checkbox"/> forceps/ vacuum
Miscarriage		<input type="checkbox"/> D&C
Termination		<input type="checkbox"/> medical treatment <input type="checkbox"/> surgical treatment
Ectopic		<input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> surgical treatment <input type="checkbox"/> medical treatment
Living		
Multiple Gestations (twins, triplets, etc.)		
Complications		

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Gynecological History

1. When was the **FIRST** day of your last menstrual period ____/____/____
2. Please indicate the age at your 1st period ____ years old
3. If your menstrual periods are regular; periods start every: ____ days
4. If your menstrual periods are irregular; periods start every: ____ to ____ days (e.g., 12 to 60)
5. How long do your periods last? ____ days
6. How would you describe your menstrual flow? light moderate heavy
7. Do you have cramps with your periods? yes no
8. Do you have bleeding in between your periods? yes no
9. Do you have bleeding after intercourse? yes no
10. What is your current method of birth control?
 none pills diaphragm Essure
 abstinence patch Nexplanon implant tubal ligation
 rhythm vaginal ring Mirena IUD vasectomy
 condoms Depo-Provera injection Paragard IUD
11. Please check any birth control methods that you did **NOT TOLERATE**?
 condoms vaginal ring Nexplanon implant Paragard IUD
 pills Depo-Provera injection Mirena IUD Essure
 patch diaphragm
12. Please indicate your age at menopause? ____ years old
13. Have you ever used Hormone Replacement Therapy? yes no
14. If YES, for how many years ____ years
15. Are you sexually active? yes no
16. Have you had any new sexual partners in the last year? yes no
17. Have you had the Gardasil vaccine? yes no
18. Have you ever had a sexually transmitted infection? yes no

19. Have you ever had an **ABNORMAL** Pap test? yes no
If yes, did you have a colposcopy? yes no
20. Have you ever had an **ABNORMAL** mammogram? yes no
If yes, what was the follow up? ultrasound surgical referral biopsy- result _____

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Please provide the date and result of the MOST RECENT of the following tests:

	Month/Year	Result
Pap Smear		
HPV Test		
Mammogram		
Bone Density Testy		
Colonoscopy		

Social History

Do you smoke?	<input type="checkbox"/> yes <input type="checkbox"/> no
How many packs per day?	<input type="checkbox"/> 1PPW <input type="checkbox"/> 2PPW <input type="checkbox"/> 1PPD <input type="checkbox"/> 2PPD <input type="checkbox"/> 3+PPD <input type="checkbox"/> _____
Do you drink alcohol?	<input type="checkbox"/> yes <input type="checkbox"/> no
How many drinks per week?	_____ # of drinks
Do you use illicit drugs?	<input type="checkbox"/> yes <input type="checkbox"/> no
What is your marital status?	<input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widow
What is your occupation?	_____

Family History (Please indicate **age** of onset in the appropriate box)

	Breast Cancer	Ovary Cancer	Uterine Cancer	Colon Cancer	Osteoporosis	Bleeding Disorders	Blood Clotting Disorders	Thyroid Disease	Cardiac Disease	Diabetes	High Blood Pressure
Mother											
Father											
Sibling											
Sibling											
Child											
Child											
Maternal GM											
Maternal GF											
Paternal GM											
Paternal GF											
Maternal Aunt											
Maternal Uncle											
Paternal Aunt											
Paternal Uncle											

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Please indicate your preferred (Name, Location, Phone)

Pharmacy (local) _____

Pharmacy (mail away) _____

Laboratory _____

Imaging Center _____

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

1. _____ (Primary Care Physician)
2. _____ (Gastroenterologist)
3. _____ (Dermatologist)
4. _____ (Cardiologist)
5. _____ (Surgeon)
6. _____ (Other) _____ (Specify)
7. _____ (Other) _____ (Specify)
8. _____ (Other) _____ (Specify)

Signature of Patient/ Guardian

Date

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By law, we are required to make available to you a copy of our Notice of Privacy Practices ("Notice"). By signing below you acknowledge that you received, or have been offered and declined, a copy of the Notice. A current copy of the Notice is also posted in the office, on our website and is available to you upon request. If the Notice is revised, you may review and obtain the new version at any time. *You may decline to sign this acknowledgement.*

Please help us to protect your privacy by answering the following questions:

1. How did you hear about us? A friend/family member Hospital Our Website Insurance company
 Other _____

2. May we obtain your medication history from your pharmacy? Yes No

3. Can we leave a detailed message on your voice mail? Yes No

*If you only have a cell phone, and choose to not get messages, you **WILL NOT** get any automatic calls, including appointment reminder calls.

4. Which phone number would you like us to use? Home Cellular Work

5. Can we release information to anyone other than you? Yes No

6. Please list each person and indicate which permissions are allowed.

(NOTE: We will NOT release any information to anyone that is not listed here.)

Name: _____

Relation: _____ Records Financials Samples

Name: _____

Relation: _____ Records Financials Samples

I have **RECEIVED** **DECLINED** a complete copy of the "Notice of Privacy Practices." This is to verify that I have read and understand the above information. By signing this statement, I am giving Manatee Gynecology, LLC and its staff permission to release my personal information as described above.

Signature of Patient

Date

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

For Office Use Only

We were unable to obtain this written acknowledgement.

Employee Initials

Date

Notes

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Appointments: Late Cancellation/Late Reschedule/No show fee

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 for 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 interventions, and the order of laboratory/diagnostic procedures."

If an abnormality is encountered or a problem/preexisting problem 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 than 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

Date