First Coast Obstetrics & Gynecology, PA
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WELCOME TO OUR PRACTICE

Name:_____D.O.B_____Date:_____
Address:_____City/State:_____Zip:_____
SS#_____Phone:_____
Secondary Phone:_____
Email Address:_____
Consent to Text: **No** or **Yes**
Marital Status: *Please circle one*: Married Single Domestic Partner Widowed Divorced
How do you *prefer* to be contacted: Phone:___ Email:___ Mail:____Text:____

How can we help you today: Follow up:____ Annual:____ New Patient:____
Problem Visit:_____

_____

Are you allergic to any Medications?_____ If yes, what?_____
_____
List Current Medications:_____
_____
Who is your primary care provider?_____
What is your primary Pharmacy?_____
In which language do you communicate?_____
In case of Emergency, whom may we contact:_____
Phone:_____Relation:_____

We are required by law to ask which RACE and what ETHNICITY best describes you (you may decline to answer)

___American Indian or Alaska Native
___Asian
___Black or African American
___Native Hawaiian or Pacific Islander
___White
___Other_____
___Decline to Report

___Hispanic or Latina
___Not Hispanic or Latina
___Other_____
___Decline to report

Please complete Insurance Information:

Insurance Co:_____Policy#_____
Name of Insured_____ Date of Birth:_____
Relationship_____

Assignment of Insurance Benefits

(FINANCIAL STATEMENT POSTED IN LOBBY)

I hereby authorize direct payment of surgical or medical benefits to *First Obstetrics & Gynecology*,*PA* for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.
I hereby authorize *First Coast Obstetrics & Gynecology,PA* to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand I may revoke this consent at any time by notifying *First Coast Obstetrics & Gynecology,PA* in writing. *First Coast Obstetrics and Gynecology,PA* has the right to refuse treatment should I revoke or refuse this consent.

Signature:_____Date:_____

Consent for Medical Information Release

There are times we are asked to give family members or others information on test results, especially if you will not be available to receive them. If you would like for us to give out information regarding your treatment and/ or test results to your family or friends, please fill in their name and their relationship to you. Make your own notes if necessary for clarification.

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

____Please check here if **No** information is to be released

I give my consent to the individual (listed above) permission to receive my Medical Information, such as, lab results, imaging results, appointments and financial information from First Coast Obstetrics and Gynecology.

Signature:_____**Date:**_____

Gynecologic History

Date of last menstrual period _____
Date of last Mammogram_____ Date of last Colonoscopy_____
Date of last Bone Density_____ Date of last Pap Smear_____
Have you ever had an abnormal Pap? **No** or **Yes** If yes, when?_____
Have you ever had HPV? **No** or **Yes** *If yes*, When?_____Treatment:_____
Have you ever had STD? **No** or **Yes** *If yes*, When?_____Treatment:_____
Have you received the HPV vaccine? **No** or **Yes** Completed series? No or Yes
Are you currently using a birth control method? **No** or **Yes** Type of birth control_____
Are you sexually active? **No** or **Yes** If IUD? What type?_____
Age of onset of period?_____ If menopausal, age of time of last period_____
Menstrual Cycle:____Regular____Irregular How many days of cycle?_____
Cramping?___Moderate.___Severe
Any GYN history we should know about?_____

_____

Obstetrics History

How many pregnancies have you had total (including miscarriages)?_____
How many deliveries?_____
Have you ever had Miscarriages?____ If yes, When?_____
Have you ever had Ectopic pregnancy?____ If yes, When?_____
Have you had any Pelvic Surgeries or Procedures?___ If Yes, What/When?_____

_____

Delivery History

Date of birth	Full Term	C-section/ Vaginal	Length of labor	weight	sex
1_____	____	_____	_____	_____	___
2_____	____	_____	_____	_____	___
3_____	____	_____	_____	_____	___
4_____	____	_____	_____	_____	___
5_____	____	_____	_____	_____	___
6_____	____	_____	_____	_____	___
7_____	____	_____	_____	_____	___

Office Policies

(Please see our full detailed Office Policy, located in lobby)

1. Your copay is due at the time of service. You are responsible for any deductible insurance amounts.

2. If your insurance requires a referral or authorization, it is your responsibility to get it.

3. Your insurance company has contracted with a lab for any blood work, Pap smear or biopsies; you should know which lab to visit for blood work. We will make every attempt to send any specimens to the correct lab.

4. Please give a 24 hour notice for cancellations.

5. You may be charged for a 25$ NO SHOW FEE. Please call our office to cancel or reschedule prior to your schedule appointment time to avoid any charges. After 3 no show appointments, no more appointments will be made. You may come in and sit in our lobby and wait to be seen. Please note, all scheduled appointments will be seen first.

6. There is a 25.00$ charge for FMLA paperwork, and may take up to 3 days to complete. There is a 30.00$ charge to fax FMLA paperwork.

7. You must contact our office, if you will be more than 15 minutes late to your appointment. Note, you may be rescheduled, if you are more than 15 minutes late of your schedule appointment time.

8. You are required to contact *First Coast Obstetrics and Gynecology, PA* if your insurance or contact information changes at any time.

9. In addition to our regular office hours, our practice has coverage 24hrs a day/7 days a week. If you are in labor after hours or have a question that can't wait, please call our office and speak to our call service to have them direct you to our provider on call. For immediate care, please call 911 or go to the nearest hospital. You can also direct non-emergency questions through the patient portal. They will be answered the next busy day.

I have read and understand the Office Policy of First Coast Obstetrics & Gynecology.

Signature:_____ Date:_____

Notice of Privacy Practices

I have read and understand the "Notice of Privacy Practices". A printed copy is located at the front desk. Upon request, you may take one.

Signature_____Date_____

Social History

Are you a cigarette/cigar smoker?___Yes___No Cig/day_____Years of use_____
Are you deaf or have difficulty hearing? ___Yes ____No
Alcohol intake: ___never ____occasionally ___daily
Are you in recovery from drug or alcohol dependency? ___Yes ___No Type_____
Do you have a current or past history of drug use? ___Yes ___No
Caffeine intake? ___ Yes ___ No amount/day: ___Yes ___No
Diet: ___Vegen ___Gluten Free___ Vegetarian ___ Diabetic ___ No restrictions
Have you ever felt threatened or unsafe in a relationship? ___Yes ___ No
Is a blood transfusion acceptable in an emergency? ___Yes ___ No

List All Surgeries:

_____Date of Surgery_____
_____Date of Surgery_____
_____Date of Surgery_____
_____Date of Surgery_____
_____Date of Surgery_____
Additional Notes:_____

Medical History

Do you have any history of:

___Cancer	___History of chicken Pox	___Heart Disease	___Arthritis
___Hypertension	___Migraines	___Seizures/Epilepsy	
___Skin problems	___Bone fractures	___Depression/Anxiety	
___Thyroid	___Asthma	__Autoimmune Disease	
___Liver disease	___Blood clots/disorders	___Urology problems	
___Abdominal digestive problems		___Psychiatric disorder	

Other:_____
_____

Family History

Please list ***IF*** your parents, siblings, maternal or paternal grandparents have medical conditions.

Name	Disease/Condition	Deceased?	**Yes**	**No**
_____	_____		___	___
_____	_____		___	___
_____	_____		___	___
_____	_____		___	___
_____	_____		___	___