Gulf Women's Center for Health & Surgery
Tammy L. Birbeck DO

Dear Patient;

We would like to take this opportunity to welcome you and thank you for choosing ***Gulf Women's Center for Health & Surgery***.

In this packet you will find the paperwork required for your visit with Dr. Birbeck. To better understand your history, it is important that you answer all questions to the best of your knowledge. Please do not leave any sections unanswered, you may enter N/A if the question does not apply to you or your previous history.

We kindly request these forms completed and returned to us no later than 1 day prior to your office visit. If the forms are not received in time, your appointment may be rescheduled to a later date. You may return the forms via fax or email but also please bring the completed original forms with you on the day of your appointment, along with a photo ID, insurance card(s) and copay if applicable.

Please arrive at least 5-10 minutes prior to your appointment. All **Co-payments, previous balance etc. will be collected at check in**.

We accept most major insurance plans including Medicare replacement plans. If unsure about our participation you may call us directly of check with your insurance carrier for clarification.

If you do not have any insurance coverage, please call the office for an estimate if one has not been provided to you over the phone. **All visits are due in full at time of service**.

We understand that emergencies may arise but if you are unable to keep your appointment we ask that you please give us at least 24 hrs. notice if possible. A fee $25.00 will be charged to you for any no call / no show appointments.

PREVIOUS MEDICAL RECORDS:

For your convenience, we have added a release of information form to complete only if applicable. An original signature is required in order to request records (digital signatures are not allowed).

Our office locations are as follows:

***Englewood Location* (Mon. Tues. Thu. Fri.)**
2061 Englewood Rd Suite 4
Englewood, Fl 34223

***North Port Location* (Wed.)**
29795 Bobcat Village Center Rd #200
North Port, Fl 34288

We look forward to meeting you. If you have any questions do not hesitate to call our office between 8:30 am and 4:00 pm Monday thru Friday.

Sincerely,

Nancy Bailon
Office Manager

Gulf Women's Center for Health & Surgery
Tammy L. Birbeck DO

Name: ____________________ **Date of Birth:** ____________________
Soc. Sec#: ____________________ **PCP Name:** ____________________
Sex: ☐F ☐M Marital status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Life Partner
Sexual Orientation: ☐Heterosexual ☐Bisexual ☐Homosexual Gender Identity: ____________
Address: ____________________ Apt #: __________
City: ____________________ State: __________ Zip: __________
Home # ____________________ Cell #: ____________________
Email: ____________________
Live here year-round? ☐Yes ☐No If No, please provide address: ____________________

Employment Status: ☐ Full Time ☐Part-Time ☐Self Employed ☐Retired
Employer's Name: ____________________ Work #: ____________________
Current/Former Occupation: ____________________

Please answer the following questions:

1. Is it O.K. to leave a detailed message on your home voicemail? ☐ Yes ☐ No
2. Is it O.K. to leave a detailed message on you cell phone? ☐ Yes ☐ No
3. Do you prefer a message with call back number only? ☐ Yes ☐ No
4. Can we call you at work? ☐ Yes ☐ No
5. Would like to receive and invitation to our secured Patient Portal? ☐ Yes ☐ No

Preferred method of contact:
☐Home Phone ☐TEXT Message ☐US Mail ☐Email ☐Patient Portal
Emergency Contact: ____________________ Phone #: ____________________ Relation: __________

PLEASE MAKE A CHOICE IN BOTH SECTIONS BELOW

1. Race: ☐American Indian/Alaska ☐ Native Black/African ☐ American White/Caucasian ☐Asian Hawaiian/Pacific Islander ☐Other ☐Unknown ☐Declined

2. Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Declined ☐Unknown

➢ *Do you have insurance Coverage?* ☐ Yes ☐NO ☐SELF PAY

1. PRIMARY INSURANCE INFORMATION
Primary Insurance Name: ____________________ ID# ____________________
Are you the Primary policy holder? ☐ Yes ☐ No Is coverage through employer? ☐ Yes ☐No
If you answered no TO THE ABOVE QUESTION, who is the Primary Policy Holder, please provide information below?
Policy holder relation to patient ☐**Spouse** ☐**Parent** ☐**Other**
Name: ____________________ Date of Birth: ____________________
Is coverage through employer? ☐ Yes ☐No

Do you have a Secondary Insurance? ☐ Yes ☐ No

2. SECONDARY INSURANCE INFORMATION
Secondary Insurance: ____________________ ID# ____________________
Are you the Primary policy holder? ☐ Yes ☐ No Is coverage through employer? ☐ Yes ☐No
If you answered NO .TO THE ABOVE QUESTION, who is the Primary Policy Holder, please provide information below?
Policy holder relation to patient ☐**Spouse** ☐**Parent** ☐**Other**
Name: ____________________ Date of Birth: ____________________
Is coverage through employer? ☐ Yes ☐No

☐Primary Physician Name: ______________________ Did he/she refer you? ☐Yes ☐No
☐Physician Assistant Name: ______________________ Did he/she refer you? ☐Yes ☐No
☐Nurse Practitioner Name: ______________________ Did he/she refer you? ☐Yes ☐No
☐Another Practitioner Name: ______________________ Did he/she refer you? ☐Yes ☐No

If you were not referred by any of the above, how did you hear about us?

☐Patient Name: ______________________
☐Insurance Name: ______________________

☐Billboard ☐Attended Lecture ☐Post card ☐Internet ☐Other: ______________

To better coordinate you cares please provide the following information for all providers in you care:
Please check YES or NO if you authorize us to send a continuity of care report to the Drs. Listed below:

	Name	Phone #	Send Continuity of Care	
Cardiologist:	Name: ____________	Phone #: ________	☐Y	☐N
Nephrologist:	Name: ____________	Phone #: ________	☐Y	☐N
Ophthalmologist:	Name: ____________	Phone #: ________	☐Y	☐N
Psychiatrist	Name: ____________	Phone #: ________	☐Y	☐N
Psychologist:	Name: ____________	Phone #: ________	☐Y	☐N
Oncologist:	Name: ____________	Phone #: ________	☐Y	☐N
Allergist:	Name: ____________	Phone #: ________	☐Y	☐N
Urologist:	Name: ____________	Phone #: ________	☐Y	☐N
Gynecologist:	Name: ____________	Phone #: ________	☐Y	☐N
Gastroenterologist:	Name: ____________	Phone #: ________	☐Y	☐N
Pulmonologist:	Name: ____________	Phone #: ________	☐Y	☐N
Endocrinologist Name:	Name: ____________	Phone #: ________	☐Y	☐N
Podiatrist Name:	Name: ____________	Phone #: ________	☐Y	☐N
Other:	Name: ____________	Phone #: ________	☐Y	☐N

Disclosures to Authorized Individuals

I understand that ***Gulf Women's Center for Health & Surgery*** may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care may be released:

Name: ______________________ Relationship: ______________________
Name: ______________________ Relationship: ______________________
Name: ______________________ Relationship: ______________________
Name: ______________________ Relationship: ______________________
Name: ______________________ Relationship: ______________________

General Consent for Examination and Treatment

I hereby consent and authorize ***Tammy L. Birbeck DO dba Gulf Women's Center for Health & Surgery*** and all physicians and ancillary medical personnel of ***Gulf Women's Center for Health & Surgery***, to perform medical examinations and provide routine medical care for all my visits to ***Gulf Women's Center for Health & Surgery***. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of ***Gulf Women's Center for Health & Surgery***. Any photographs or other images taken will become part of my medical record. ***Gulf Women's Center for Health & Surgery*** will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that ***Gulf Women's Center for Health & Surgery*** will provide me with information and forms prior to such procedures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and understand ***Gulf Women's Center for Health & Surgery***'s HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that ***Gulf Women's Center for Health & Surgery*** has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, ***Gulf Women's Center for Health & Surgery*** will post a new notice in the office. I may contact ***Gulf Women's Center for Health & Surgery*** at any time to obtain a current copy of the HIPAA Notice of Privacy Practices.

Consent to Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize ***Gulf Women's Center for Health & Surgery*** to use and disclose my health information, which includes all or any part of my medical records, including drug or alcohol treatment information, genetic, genetic counseling and genetic testing information, HIV/AIDS information, and any other information concerning my diagnosis or treatment, as well as demographic information, by and to its workforce members and to health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of ***Gulf Women's Center for Health & Surgery***. I understand that, for example, my health information may be used or disclosed by ***Gulf Women's Center for Health & Surgery*** to: provide for my care and treatment; communicate among various health care professionals who are involved in my care or treatment; bill for and obtain payment for care and treatment provided by ***Gulf Women's Center for Health & Surgery***; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations. In addition, I understand ***Gulf Women's Center for Health & Surgery*** may release my protected health information as required by law or court order.

Assignment and Authorization of Benefits

I authorize the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing. I hereby ***authorize Gulf Women's Center for Health & Surgery*** to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to ***Gulf Women's Center for Health & Surgery*** (or the party who accepts assignment). I certify that the information I have reported about my insurance coverage is correct. I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I agree to pay any collection fees, including attorney fees if necessary to collect my debt.

Acknowledgement

I have read and understand the information of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document. I understand that if I have checked the box "detailed message," I agree that ***Gulf Women's Center for Health & Surgery*** may leave any of the following detailed messages at the indicated telephone number: appointment reminders, insurance/financial issues, biopsy or other test results, and any other information regarding care/treatment. I understand that it is my responsibility to contact ***Gulf Women's Center for Health & Surgery*** within 14 days regarding my test results if I do not hear from them. I understand that it is my responsibility to notify the physician's office, in writing, if there is a change in this information. I release ***Gulf Women's Center for Health & Surgery*** and its staff, from any liability for the release of information pertaining to my medical care.

By signing this form, I acknowledge and agree to the information, responsibilities and obligations outlined in the sections above.

____________________	____________________	__________
Patient Printed Name	Patient Signature	Date
Authorized Individual (Parent/Guardian) Name	Authorized Individual Signature	Date

Name: ______________________________ Date of Birth: ______________________
PCP Name: ___________________________ Referred by PCP? ☐ Yes ☐ No

PAST MEDICAL HISTORY QUESTIONNAIRE

This form will help collect important information about your medical history, please complete ALL sections to the best of your ability and return to us prior to your visit.

Reason for today's visit ☐ New Patient Annual Gynecological Exam (Wellness Exam)
☐ New Patient Diagnostic (**briefly explain problem** below :)

Reason: ____

GYN HISTORY - Please do not skip or leave blank.

Approximate date/year of last menstrual period: ________________________
How old were you when it 1st started? ____________ Cramps / Pain ☐ Yes ☐ No
Periods are/were: ☐ Light ☐ Medium ☐ Heavy ☐ Regular ☐ Irregular
Have you ever been on Hormone Replacement Therapy? ☐ Yes ☐ No If yes # years? ________
Have you ever taken Fertility Drugs ☐ Yes ☐ No
Do you perform self-breast Exams? ☐ Yes ☐ No
Are you currently on Birth Control? ☐ Yes ☐ No Refills Needed? ________
Have you ever been sexually abused? ☐ Yes ☐ No

PREVIOUS PREGNANCY HISTORY

Total Pregnancies: _____ Total Children Born Alive: _____ Total Stillbirths: _____
Total Miscarriages: _____ Total Abortions: _____

Delivery information

Date: ________ Wks. _____ Delivery Type: ____________ Sex: _____
Date: ________ Wks. _____ Delivery Type: ____________ Sex: _____
Date: ________ Wks. _____ Delivery Type: ____________ Sex: _____
Date: ________ Wks. _____ Delivery Type: ____________ Sex: _____
Date: ________ Wks. _____ Delivery Type: ____________ Sex: _____

Please check if you have had the following preventative services and date/year of test

Pap smear/pelvic:	☐ Yes	☐ No	Approximate Date: ________	☐ Normal	☐ Abnormal
Mammogram	☐ Yes	☐ No	Approximate Date: ________	☐ Normal	☐ Abnormal
Bone Density	☐ Yes	☐ No	Approximate Date: ________	☐ Normal	☐ Abnormal
Colonoscopy	☐ Yes	☐ No	Approximate Date: ________	☐ Normal	☐ Abnormal
HIV test	☐ Yes	☐ No	Approximate Date: ________	☐ Normal	☐ Abnormal

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Name: ______________________________________ Date of Birth: ____________________________

SOCIAL HISTORY

Tobacco use: ☐Never ☐ Quit (when) ___________ ☐Current smoker: _____Packs/day, _____ years
Alcohol use: ☐No ☐Yes If yes, type, how many drinks/how often: ______________________________
Illicit Drug use (including marijuana, cocaine, steroids): ☐Never ☐Past ☐Current
Describe: ____
Sexual Activity: ☐Never ☐Sexually active Age of 1st intercourse _______ Total # of Partners _______
Currently sexually active? ☐Yes ☐No Safe Sex Practices? ☐Yes ☐No
Length of time in current relationship? __________ Your current partners gender is? ☐ Male ☐ Female ☐ N/A
Please check off each one that applies to you below.
Do you: ☐ Wear Seat belts ☐ Exercise ☐ Have smoke detectors in home ☐ Have a living Will

PAST MEDICAL HISTORY

Diagnosed with:	Yes	No	Please describe:
Anemia	☐	☐	____________
Arthritis	☐	☐	____________
Asthma	☐	☐	____________
Bacterial Vaginosis	☐	☐	____________
Birth Defects	☐	☐	____________
Chronic Lung Disease	☐	☐	____________
Diabetes	☐	☐	____________
Eye Disease	☐	☐	____________
Heart Disease	☐	☐	____________
High Blood Pressure	☐	☐	____________
Kidney Disease	☐	☐	____________
Liver Disease	☐	☐	____________
Psychiatric Disorder	☐	☐	____________
Seizures/Epilepsy	☐	☐	____________
Stomach Intestinal Disease	☐	☐	____________
Stroke	☐	☐	____________
Thyroid Disease	☐	☐	____________
Ovarian Cyst(s)	☐	☐	____________
Fibroid in Uterus	☐	☐	____________

CANCER SECTION	Yes	No	Please describe:
Breast Cancer	☐	☐	____________
Cervical Cancer	☐	☐	____________
Colon Cancer	☐	☐	____________
Ovarian Cancer	☐	☐	____________
Uterine Cancer	☐	☐	____________
Other Cancer	☐	☐	____________

STD/STI SECTION	YES	NO	
Chlamydia	☐	☐	____________
Genital Warts	☐	☐	____________
Gonorrhea	☐	☐	____________
Herpes	☐	☐	____________
HIV	☐	☐	____________
HPV	☐	☐	____________
NGU/NSU	☐	☐	____________
Syphilis	☐	☐	____________
Trichomonas (trich)	☐	☐	____________

Other: Please Describe below:

____
____
____

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Name: ______________________________ Date of Birth: ______________________

SURGICAL HISTORY

Tonsils ☐Yes ☐No Approximate Date: ________
Tubal Pregnancy ☐Yes ☐No Approximate Date: ________
Breast Biopsy ☐Yes ☐No Approximate Date: ________
Cervical Biopsy ☐Yes ☐No Approximate Date: ________
Lumpectomy ☐Yes ☐No Approximate Date: ________ ☐Right Breast ☐Left Breast ☐Both
Mastectomy ☐Yes ☐No Approximate Date: ________ ☐Right Breast ☐Left Breast ☐Both
Bladder Repair ☐Yes ☐No Approximate Date: ________
LEEP ☐Yes ☐No Approximate Date: ________
Hysterectomy ☐Yes ☐No Approximate Date: ________ ☐Vaginal ☐Abdominal ☐Laparoscopic ☐ Da Vinci
Ovary Removed ☐Yes ☐No Approximate Date: ________ ☐Left Ovary ☐Right Ovary ☐Both
D & C ☐Yes ☐No Approximate Date: ________
Laparoscopy ☐Yes ☐No Approximate Date: ________
Tubal Ligation ☐Yes ☐No Approximate Date: ________
Appendectomy ☐Yes ☐No Approximate Date: ________
Hemorrhoidectomy ☐Yes ☐No Approximate Date: ________
Gallbladder ☐Yes ☐No Approximate Date: ________ ☐OPEN ☐Laparoscopic

FAMILY HISTORY

	Mother	Father	Sister	Brother	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Living								
Deceased								
High Blood Pressure								
Diabetes								
Breast Cancer								
Uterine Cancer								
Colon Cancer								
Ovarian Cancer								
Other Cancer type:								
Thyroid Trouble								
Kidney Trouble								
Heart Disease								
Anemia								
Birth Defects								
Other:								

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Name: ______________________ Date of Birth: ______________________

ALLERGIES: Please list all allergies or intolerance to medications: Please include type of reaction.

☐ NO KNOWN ALLERGIES ☐ DRUG ALLERGIES ☐ ENVIRONMENTAL

List Allergies & Type of Reaction & approximate date/yr.

1. ______________________ ☐ Severe ☐ Moderate ☐ Mild
2. ______________________ ☐ Severe ☐ Moderate ☐ Mild
3. ______________________ ☐ Severe ☐ Moderate ☐ Mild
4. ______________________ ☐ Severe ☐ Moderate ☐ Mild

FOR ANY ADDITIONAL ALLERGIES, PLEASE PROVIDE A SEPARATE SHEET

PHARMACY INFORMATION

Preferred Pharmacy Name: ______________________ Phone # ______________________
Mail Order Pharmacy: ______________________ Phone # ______________________

MEDICATION LIST-PLEASE INCLUDESTRENGTH (For additional medications please provide a separate form)

	MEDICATION NAME	STRENGTH	FREQUENCY	TYPE/FORM
1.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream
2.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream
3.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream
4.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream
5.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream
6.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream
7.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream
8.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream
9.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream
10.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream
11.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream
12.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream
13.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream
14.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream
15.			____ x per day	☐ Capsule ☐ Tablet ☐ Cream

Gulf Women's Center for Health & Surgery
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Name: ______________________________ Date of Birth: ______________________

REVIEW OF SYSTEMS Please CHECK all that are applicable (within the last 6-12 months)

CONSTITUTIONAL
☐ Negative
☐ Fever ☐ feeling poorly ☐ weight gain ☐ weight loss ☐ Chills ☐ feeling tired

EYES
☐ Negative
☐ Eye Pain ☐ spots in eyes ☐ glasses ☐ vision changes

EAR/NOSE/THROAT
☐ Negative
☐ Earaches ☐ nose bleeds ☐ sore throat ☐ Hearing loss ☐ Sinus problem

CARDIOVASCULAR
☐ Negative
☐ Chest pain ☐ fast hear rate ☐ slow heart rate ☐ Edema

RESPIRATORY
☐ Negative
☐ short of breath ☐ cough ☐ Wheezing ☐ respiratory distress in sleep

GASTROINTESTINAL
☐ Negative
☐ Abdomen pain ☐ constipation ☐ heartburn ☐ Vomiting ☐ diarrhea ☐ black stool
☐ Nausea ☐ early satiety ☐ maroon colored stool (hematochezia)

OB/GYN GU
☐ Negative
☐ Urine Frequency ☐ blood in urine ☐ incomplete emptying of bladder ☐ Nocturia ☐ cloudy urine
☐ incontinence ☐ Dysuria ☐ odor in urine ☐ urgency urine

OB/GYN
☐ Negative
☐ Abn. bleeding ☐ vulvar itching ☐ vaginal itching ☐ Irregular menses
☐ pelvic pain ☐ Pain w/ menses ☐ bleeding after sex ☐ vaginal dryness
☐ Pain w/intercourse ☐ vulvar pain ☐ vaginal discharge
☐ Anorgasmia ☐ decreased libido ☐ vaginal odor

MUSCULOSKELETAL
☐ Negative
☐ Arthralgia ☐ joint swelling ☐ limb pain ☐ joint stiffness ☐ limb swelling

INTEGUMENTARY(SKIN)
☐ Negative
☐ Acne ☐ itching ☐ breast pain ☐ Breast discharge ☐ breast lump ☐ mole change

NEUROLOGICAL
☐ Negative
☐ Confused ☐ dizziness ☐ limb ☐ weakness ☐ Memory issues ☐ headaches
☐ Migraines ☐ difficulty walking

PSYCHIATRIC
☐ Negative
☐ Suicidal ☐ Anxiety ☐ changes in personality ☐ Sleep disturbances
☐ Depression ☐ Emotional problems

ENDOCRINE
☐ Negative
☐ Hair loss ☐ muscle weakness ☐ feeling weak ☐ Hot flashes ☐ deepening of the voice
☐ dry skin ☐ Heat/cold intolerance

HEMATOLOGY/IMMUNOLOGY
☐ Negative
☐ Easy bleeding ☐ swollen glands ☐ easy bruising ☐ seasonal allergies

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AUTHORIZATION TO REQUEST RECORDS

Patient Information:

Name: ____ Date of Birth: ___________________

Address: ____

City: ____________________ State: ________ Zip: ___________ Phone: ______________________

Request Medical Information from:

Name: ____

Address: ____

City: ____________________State: _______ Zip: _____________

Phone: __________________ Fax: _________________________

Send Medical Information to:

Tammy L. Birbeck DO
Gulf Women's Center for Health & Surgery
2061 Englewood Rd Suite 4
Englewood, FL 34223-1747
941-681-2042 Phone
941-208-5982 Fax

☐ Release the complete medical record in your possession concerning my illness and/or treatment unless otherwise requested.

☐ All Records during the period from ___________________ to ____________________

☐ Other: ____

Reason for your request:

☐ Moving out of the area

☐ Primary physician needs records

☐ Copy for northern physician

☐ Other (please explain): ____

By signing below, you authorize the release of the information requested above. I understand that information such as Mental Health Records, communicable diseases, alcohol/drug abuse treatments etc may be released unless specifically stated not to be released.

____ _________________________

Patient or Legal Representative Date