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.

New patients **We kindly request that your information be completed prior to scheduling your office visit**. You may also 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 20 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
Tel. 941-681-2042 Fax 941-208-5982

***North Port Location* (Wed.)**
29795 Bobcat Village Center Rd #200
North Port, Fl 34288
Tel. 941-681-2042 Fax 941-208-5982

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,

Dr. Birbeck & Staff

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

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Sex: ☐F ☐M Soc. Sec#: _____
Marital status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Life Partner

PRIMARY CARE PROVIDER INFORMATION:

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

Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Home # _____ Cell #: _____
Email: _____
Do you live here year-round? ☐ **Yes** ☐**NO** **If no, please list other address:**
Address: _____
City, State, Zip _____
Phone #_____
Responsible Party: ☐Self ☐Guarantor: _____
Employment Status: ☐ Full Time ☐Part-Time ☐Self Employed ☐Retired

Guarantor address same as patient . ☐ **Yes** ☐**NO** If no, what is the Guarantor Name
Address: _____City, State, Zip _____
Phone #_____

PLEASE MAKE A CHOICE IN BOTH SECTIONS BELOW

Race: ☐American Indian/Alaska ☐ Native Black/African ☐ American White/Caucasian
☐Asian Hawaiian/Pac.Islander ☐Other ☐Unknown ☐Declined
Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Declined ☐Unknown ☐Declined

EMERGENCY CONTACT: _____ Phone #: _____Relation: _____

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

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

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Sex: ☐F ☐M

INSURANCE COVERAGE

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

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.

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

No Show Policy

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.

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

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

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Sex: ☐F ☐M

PRIMARY CARE PROVIDER INFORMATION:

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

To better coordinate you care 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:

Cardiologist:	Name: _____	Phone #: _____	Send Continuity of Care: ☐Y	☐N
Nephrologist:	Name: _____	Phone #: _____	Send Continuity of Care: ☐Y	☐N
Psychiatrist	Name: _____	Phone #: _____	Send Continuity of Care: ☐Y	☐N
Psychologist:	Name: _____	Phone #: _____	Send Continuity of Care: ☐Y	☐N
Oncologist:	Name: _____	Phone #: _____	Send Continuity of Care: ☐Y	☐N
Urologist:	Name: _____	Phone #: _____	Send Continuity of Care: ☐Y	☐N
Gastroenterologist:	Name: _____	Phone #: _____	Send Continuity of Care: ☐Y	☐N
Pulmonologist:	Name: _____	Phone #: _____	Send Continuity of Care: ☐Y	☐N
Endocrinologist Name:	Name: _____	Phone #: _____	Send Continuity of Care: ☐Y	☐N
Other:	Name: _____	Phone #: _____	Send Continuity of Care: ☐Y	☐N

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.

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

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

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Sex: ☐F ☐M

MEDICATION AND PHARMACY INFORMATION

Local Pharmacy Name:
_____ Phone # _____City:_____, State_____
Mail Order Pharmacy:
_____ Phone # _____City:_____, State_____

Do you give us consent to retrieve your historical medication electronically from your Pharmacy? ☐ **Yes** ☐ **No If you answered no, please select one:**

☐ **See attached medication list**
☐ **I am listing my medications below:**

CURRENT MEDICATION LIST-PLEASE INCLUDE STRENGTH

	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

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Sex: ☐F ☐M

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.

Patient Signature _____ Date:_____

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

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Sex: ☐F ☐M
☐Primary Physician Name: _____

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.

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

Reason: _____

PAST MEDICAL HISTORY

Diagnosed with:	**Yes**	**No**	**Please describe:**
Anemia	☐	☐	_____
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Bacterial Vaginosis	☐	☐	_____
Birth Defects	☐	☐	_____
Chronic Lung Disease	☐	☐	_____
Diabetes	☐	☐	Type:_____
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	☐	☐	_____

SURGICAL HISTORY

Tonsils	☐Yes	☐No	Approximate Date: _____	
Tubal Pregnancy	☐Yes	☐No	Approximate Date: _____	
Breast 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
Colonoscopy	☐Yes	☐No	Approximate Date: _____	Findings if any:_____

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HOSPITALIZATION HISTORY

Date (Mo/Yr): _____ Reason _____
Date (Mo/Yr): _____ Reason _____
Date (Mo/Yr): _____ Reason _____

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

GYN HISTORY (Please answer all questions IF IT DOES NOT APPLY PLEASE WRITE N/A)

Pap smear/pelvic: ☐Yes ☐No Approximate Date: _____ ☐Normal ☐Abnormal
If Abnormal result if known: ☐ASCUS ☐CIS ☐LSIL ☐HGSIL ☐Treated with cryo ☐Treated w/ laser ☐LEEP
Mammogram ☐Yes ☐No Approximate Date: _____ ☐Normal ☐Abnormal

MENSTRUATION:

Approximate date of last menstrual period: _____
How old were you when it 1st started? _____ Cramps / Pain ☐Yes ☐No
Periods are/were: ☐Light ☐Medium ☐Heavy ☐Regular ☐Irregular

BIRTH CONTROL:

Are you currently on Birth Control? ☐Yes ☐No If yes, what type: ☐Oral ☐Condoms ☐Mirena IUD
☐Nexplanon ☐Diaphragm ☐Nuva Ring ☐other:_____
If no, have you ever used birth control? ☐Yes ☐No
If yes, what type did you use: _____

Have you ever been on Hormone Replacement Therapy? ☐Yes ☐No If yes # years? _____
Bone Density ☐Yes ☐No Approximate Date: _____ ☐Normal ☐Abnormal
Do you perform self-breast Exams? ☐Yes ☐No

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Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Sex: ☐F ☐M

OB HISTORY

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

Delivery information

Date: _____ Wks. _____ ☐Vaginal Delivery ☐C-Section
Date: _____ Wks. _____ ☐Vaginal Delivery ☐C-Section
Date: _____ Wks. _____ ☐Vaginal Delivery ☐C-Section
Date: _____ Wks. _____ ☐Vaginal Delivery ☐C-Section
Date: _____ Wks. _____ ☐Vaginal Delivery ☐C-Section
Date: _____ Wks. _____ ☐Vaginal Delivery ☐C-Section
Date: _____ Wks. _____ ☐Vaginal Delivery ☐C-Section

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								
Genetic Disorder:								

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SOCIAL HISTORY

Tobacco use: ☐Never ☐ Quit (when) _____ ☐Current smoker: _____Packs/day, _____ years
Alcohol use: ☐No ☐Yes If yes, type, how many drinks/how often: _____
Caffeine Intake: ☐No ☐Yes If yes, type, how many /how often: _____
Illicit Drug use ☐Never ☐Past ☐Current
Describe: _____
Do you use Marijuana? ☐No ☐Yes If yes, do you have a Medical Marijuana Card? ☐Yes ☐ No

SEXUAL HISTORY

Sexual Activity: ☐Never ☐Sexually active
Currently sexually active? ☐Yes ☐No If yes, please answer the following:
☐with men ☐with women ☐with both men & women ☐with neither
Are you having any Sexual problems? ☐Yes ☐No
If yes, please check any that apply: ☐bleeding after sex ☐vaginal dryness ☐Pain w/intercourse
☐vulvar pain ☐vaginal discharge ☐Anorgasmia
☐ decreased libido ☐ vaginal odor

Have you had any Sexually Transmitted Diseases? ☐Yes ☐ No
If yes, please check all that apply:

☐Chlamydia ☐Genital Warts ☐Gonorrhea ☐Herpes ☐HIV ☐HPV ☐ Syphilis ☐Trichomonas

Total # of Partners _____ Do you use protection? ☐Yes ☐No
Age of 1st intercourse _____
Sexual Orientation: ☐Heterosexual ☐Bisexual ☐Homosexual
Have you ever been sexually abused? ☐Yes ☐No
Domestic Violence? ☐Yes ☐No
Verbal Abuse? ☐Yes ☐No

Miscellaneous Section: Please check off each one that applies to you below:

Live with: ☐Spouse/Partner ☐Family ☐Alone ☐Friends
Do you: ☐ Exercise ☐ Have smoke detectors in home ☐ Have a living Will

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Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Sex: ☐F ☐M

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