Gainesville Gynecology Group
6730 N.W. 11th Place
Gainesville, Florida 32605
Phone: 352-331-3234 Fax: 352-332-7095

Name: _____ **Date of Birth:** ___/___/_____
Address: _____ **Apt.** _____
City & State: _____ **Zip Code:** _____
Social Security Number: _____-_____-_____
Email: _____
Cell: (_____) _____-_____ **Home:** (_____) _____-_____ **Work:** (_____) _____-_____

PLEASE READ BELOW

We ask for your email and phone numbers because we are transitioning to a new electronic health record. This record will allow better patient access and communication. The office will invite you to join the patient portal. A pin number or your mobile phone number can be used to set up your portal account. The portal is accessed through:

gainesvillegynecology.com

my.patientfusion.com

As gynecologists, we realize we are dealing with sensitive information. We will **NEVER** deliver sensitive information via email. We will just direct you to view your results on the portal.

Please let us know ways that we can contact you below knowing we will protect your privacy.

Ok to contact me by **text:** _____**Yes** _____**No**
Ok to contact me by **email:** _____**Yes** _____**No**
Ok to contact me by **phone:** _____**Yes** _____**No**

Which is your preferred method of contact? (circle) **EMAIL CELL PHONE HOME PHONE**

Ethnicity:
____ Hispanic or Latino
____ Non Hispanic or Latino
____ Decline to Specify

Race:
____ American Indian/Alaska Native
____ Asian
____ Native Hawaiian or other Pacific Islander
____ Black/African American
____ White
____ Decline to Specify

Preferred Language:
____ English
____ Spanish
Other_____

Emergency Contact Information:

Name: _____ **Relationship** _____
Phone: (_____) _____-_____

Gainesville Gynecology Group

Kelli C. Ross, M.D. **Jennifer L. Alderman, M.D.** **Megan Wilson, ARNP**

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Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your medication history. A medication history is a list of prescription medications that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important in helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements, or herbal remedies. It is still very important for us to take the time to discuss everything you are taking and for you to point out to us any errors in your medication history.

I give permission for Gainesville Gynecology Group to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Print Patient Name DOB

Signature Date

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LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATION RELEASE INFORMATION

1. RELEASE OF INFORMATION: I, the below named patient, do hereby authorize the physician examining and/or treating me to release any third payer, such as an insurance company or governmental agency, any medical, psychiatric, alcohol or drug related condition and recommending diagnosis and treatment when requested by such third party for it's use in connection with determining a claim for payment for such treatment and/or diagnosis.
2. PHYSICIANS INSURANCE ASSIGNMENT: I, the below named patient, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.
3. MEDICARE/MEDICAID: Patient's certification authorization to release information and payment request: I certify that the information given by me in applying for payment under Title XVII/XIX of the Social Security Administration Division of Family Services or its intermediaries or carriers and any information needed for this or a related Medicare/Medicaid claim is accurate to my knowledge. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.
4. ANNUAL AND SICK VISITS: An annual visit means the patient has NO complaints or symptoms. Most insurance companies DO cover routine examinations, including MEDICARE. However, if you have a problem there may be an office visit charge as well. You will be responsible for all non-covered services, copays, deductibles and coinsurances.
5. I PERMIT A COPY OF THESE ASSIGNMENTS AND AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payer within a reasonable period of time, not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to a reasonable attorney's fee and charges for collection.

Signature: _____ Date: ____/____/_____

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RELEASE OF INFORMATION

By federal law, we are unable to speak to anyone other than the patient about medical or financial information. Please list below anyone that you grant permission for our physicians and/or medical staff to speak with regarding your medical care and/or financial information.

I HEREBY GIVE MY PERMISSION FOR THE FOLLOWING PEOPLE TO SPEAK ON MY BEHALF REGARDING MY MEDICAL CARE AND/OR FINANCIAL INFORMATION:

Name Relationship

Name Relationship

Name Relationship

Signature Date

I WISH THAT NO ONE BE GIVEN ANY INFORMATION REGARDING MY MEDICAL AND/OR FINANCIAL INFORMATION EXCEPT FOR MYSELF:

Signature Date

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Authorization for Release of Protected Health Information

*****Signing this form allows our office to obtain prior medical records from other physicians, hospitals, etc. if needed*****

Patient Name: _____ DOB: ____/____/____
Social Security Number: ____-____-____ Phone: _____

Name of facility to release to:

Gainesville Gynecology Group Phone: 352-331-3234
6730 NW 11th Place **Fax: 352-332-7095**
Gainesville, Florida 32605

Description of information to be disclosed (TO BE FILLED OUT BY OFFICE):

_____

_____

I acknowledge, and hereby consent to such, that the released information may contain alcohol and/or drug abuse, mental health, and HIV and STD testing and results.
_____ **(Initial)**

I understand that this form is strictly voluntary and refusal to sign will not affect the treatment provided to me, payment, enrollment in a health plan, or eligibility for benefits. I have the right to revoke this authorization at any time. If I chose to do so, I must submit this in writing, and it will not apply to any information already released as a result of this authorization.

_____
Signature of Patient

_____
Printed Name of Patient

NAME _____ **DOB** _____

MEDICATION ALLERGIES

_____
_____
_____
_____

FOOD ALLERGIES

_____
_____
_____

ENVIRONMENTAL ALLERGIES

_____
_____
_____

MEDICATIONS

_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY — MARK **X** IF YES

ASTHMA	
BLEEDING DISORDER	
BREAST CANCER	
HIGH BLOOD PRESSURE	
DIABETES	
HIGH CHOLESTEROL	
HEART DISEASE	
HEART ATTACK	
STROKE	
COPD	
HYPOTHYROIDISM	
IRRITABLE BOWEL	
DEPRESSION	
ANXIETY	
FIBROMYALGIA	
ARTHRITIS	
DIVERTICULITIS	
REFLUX	
KIDNEY STONES	
CANCER(TYPE)	
DVT(BLOOD CLOT IN LEG)	
PE(BLOOD CLOT IN LUNG)	
GLAUCOMA	

WRITE IF NOT LISTED ABOVE

_____
_____

SOCIAL HISTORY

CURRENT TOBACCO USE	YES	NO
PRIOR TOBACCO USE	YES	NO
YEARS OF TOBACCO USE	_____	YRS
ALCOHOL	YES	NO
VOCATION	YES	NO
LIST JOB TYPE	_____	
DISABLED	YES	NO
HOMEMAKER	YES	NO
STUDENT	YES	NO
MARRIED	YES	NO

MENSTRUAL HISTORY

AGE OF 1ST PERIOD	_____
DAYS BETWEEN PERIODS	_____
CRAMPS	MILD
(CIRCLE)	MODERATE
	SEVERE
CHANGE PROTECTION	EVERY 30 MIN
(CIRCLE)	EVERY HOUR
	EVERY 2 HOURS
	EVERY 3 HOURS

SURGICAL HISTORY	MARK X IF YES
APPENDECTOMY	
TUBES TIED	
BREAST BIOPSY BENIGN	
BREAST CANCER SURGERY	
GALLBLADDER REMOVAL	
COLON SURGERY	
CONE BIOPSY/LEEP	
D AND C	
UTERINE ABLATION	
LAPAROSCOPY	
HEART SURGERY	
HERNIA SURGERY	
ABDOMINAL HYSERECTOMY	
VAGINAL HYSTERECTOMY	
ROBOTIC HYSTERECTOMY	
OVARIES REMOVED	
INCONTINENCE SURGERY	
PELVIC SURGERY	
ENDOMETRIOSIS SURGERY	
HIP SURGERY	
KNEE SURGERY	
BACK SURGERY	
TONSILLECTOMY	
EAR SURGERY	
WRITE IF NOT LISTED ABOVE	

GYN HISTORY	MARK X IF YES
GONORRHEA	
CHLAMYDIA	
PID	
HERPES	
ABNORMAL PAP	
CROTHERAPY	
LEEP PROCEDURE	
CONE BIOPSY	

FAMILY HISTORY	MARK X IF YES
HEART DISEASE	
DIABETES	
BREAST CANCER	
OVARIAN CANCER	
COLON CANCER	
UTERINE CANCER	
BLOOD CLOTS(DVT/PE)	

PREVENTATIVE	
MAMMOGRAM(>40 YO)	
COLONOSCOPY(>50 YO)	
PAP(>21 YO)	
HPV VACCINE(12-27 YO)	

PHARMACY INFORMATION		
PHARMACY BRAND		
PHARMACY STREET		
PHARMACY CITY		NO
MAIL IN PHARMACY	YES	
MAIL IN PHARMACY NAME		

OB HISTORY	RECORD #
VAGINAL BIRTH #	
CESAREAN SECTION #	
MISCARRIAGE #	
ABORTION #	
ECTOPIC #	
LIVING CHILDREN #	
ADOPTED CHILDREN #	

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Health Assessment For Women

Name: _____ Date: _____

E-Mail: _____ Age: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		