

Gainesville Gynecology Group  
6730 N.W. 11<sup>th</sup> Place  
Gainesville, Florida 32605  
Phone: 352-331-3234 Fax: 352-433-4828

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ Apt. \_\_\_\_\_  
City & State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ (Please provide at least the last four digits)  
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](http://gainesvillegynecology.com)**  
**[my.patientfusion.com](http://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 **Preferred Language:** \_\_\_\_\_ English  
\_\_\_\_\_ Asian \_\_\_\_\_ Spanish  
\_\_\_\_\_ Native Hawaiian or other Pacific Islander  
Other \_\_\_\_\_  
\_\_\_\_\_ Black/African American  
\_\_\_\_\_ White  
\_\_\_\_\_ Decline to Specify

**Emergency Contact Information:**

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

# Gainesville Gynecology Group

6730 N.W. 11<sup>th</sup> Place

Gainesville, Florida 32605

Phone: 352-331-3234 Fax: 352-433-4828

## THIS PORTION IS TO BE FILLED OUT BY THE OFFICE:

DATE: \_\_\_\_\_

TO: \_\_\_\_\_

FAX: \_\_\_\_\_

\_\_\_\_\_

PHONE: \_\_\_\_\_

FROM: Gainesville Gynecology Group  
6730 NW 11<sup>th</sup> Pl  
Gainesville, FL 32605

Phone: 352-331-3234

Fax: 352-433-4828

Email: [GGG@GainesvilleGynecology.com](mailto:GGG@GainesvilleGynecology.com)

## PLEASE FAX OR EMAIL THE FOLLOWING RECORDS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PATIENT: PLEASE READ, FILL OUT, INITIAL AND SIGN THIS PORTION:

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.

Patient Initials: \_\_\_\_\_

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.

Patient Printed Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Last 4 Digits of Social Security Number: \_\_\_\_\_

Date Signed: \_\_\_\_\_

# Gainesville Gynecology Group

Kelli C. Ross, M.D.

Jennifer L. Alderman, M.D.

Megan Wilson, ARNP

6730 N.W. 11<sup>th</sup> Place

Gainesville, Florida 32605

Phone: 352-331-3234 Fax: 352-433-4828

## 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

# Gainesville Gynecology Group

Kelli C. Ross, M.D.

Jennifer L. Alderman, M.D.

Megan Wilson, ARNP

6730 N.W. 11<sup>th</sup> Place

Gainesville, Florida 32605

Phone: 352-331-3234 Fax: 352-433-4828

## 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

**\*\*SIGN HERE IF YOU HAVE ANYONE LISTED ABOVE THAT YOU WISH TO SHARE YOUR MEDICAL CARE AND/OR FINANCIAL INFORMATION WITH.**

**(OR)**

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

---

Signature Date

**\*\*ONLY SIGN HERE IF YOU DO NOT WISH TO SHARE YOUR MEDICAL CARE AND/OR FINANCIAL INFORMATION WITH ANYONE AT ALL.**

## **SMS Text Message Consent Form**

Gainesville Gynecology Group will be offering you the ability to receive SMS text messages reminders for your scheduled appointments. In addition to appointment reminders, we may occasionally send messages regarding upcoming events at our office.

Messages are generated over a secure server, however keep in mind they are being transmitted over a public network to a personal phone. We will never transmit any information that would enable a patient to be identified or any specific medical information. Standard text messaging rates apply through your mobile phone carrier.

***The SMS service should not be solely relied upon, as the responsibility of attending and cancelling appointments still remains with the patient. However, we hope that this service will make things easier.***

I consent to Gainesville Gynecology Group contacting me by text message for the purpose of appointment reminders and occasional updates regarding special office events.

Patient Name:

Date of Birth:

Cell Phone #:

---

Signature:

Date:

---

**We will NOT send out any text messages unless the form is completed and signed. You may revoke your written consent at any time.**

# Gainesville Gynecology Group

**Kelli C. Ross, M.D.**

**Jennifer L. Alderman, M.D.**

**Megan Wilson, ARNP**

6730 N.W. 11<sup>th</sup> Place

Gainesville, Florida 32605

Phone: 352-331-3234 Fax: 352-433-4828

## 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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 HYSTERECTOMY \_\_\_\_\_
- 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** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PHARMACY INFORMATION**

- PHARMACY BRAND \_\_\_\_\_
- PHARMACY STREET \_\_\_\_\_
- PHARMACY CITY \_\_\_\_\_ NO
- MAIL IN PHARMACY YES \_\_\_\_\_
- MAIL IN PHARMACY NAME \_\_\_\_\_

**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) \_\_\_\_\_

**OB HISTORY** RECORD #

- VAGINAL BIRTH # \_\_\_\_\_
- CESAREAN SECTION # \_\_\_\_\_
- MISCARRIAGE # \_\_\_\_\_
- ABORTION # \_\_\_\_\_
- ECTOPIC # \_\_\_\_\_
- LIVING CHILDREN # \_\_\_\_\_
- ADOPTED CHILDREN # \_\_\_\_\_



# Gainesville Gynecology Group

## 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		