Welcome New Patient

Welcome to Dr. Kathy Santoriello's gynecology practice. We are pleased you've chosen us and we look forward to providing personalized, compassionate care in a small, friendly and relaxed environment.

Preparing for Your First Visit

To help make your first appointment smooth, please:

- Complete the enclosed new patient paperwork: Bring the completed forms along to your appointment.
- Bring necessary documents: These include your insurance card(s) or photocopy, a valid photo ID, and a referral, if applicable. Also bring a list of current medications and the names of your primary care provider and any pertinent medical records.
- As a specialty practice, we collect all copays and out-of-pocket expenses at the time of your visit. We encourage you to bring cash or a check to avoid the small service fee charged by the credit card company.
- Plan to arrive 15 minutes early: This allows time for registration.

What to Expect

The first appointment will include a consultation, medical history review, and likely a pelvic examination. A friend or family member is welcome to join. While the practice aims to stay on schedule, delays can occur, so inform the front desk if you have time constraints.

The practice is committed to providing high-quality care and building a trusting relationship. Our appointment hours are Monday through Thursday 9:00 am – 3:40 pm and Fridays 9:00 am till 1:00 pm. Although we do offer same-day appointments when available, we encourage making appointments as far in advance as possible. Our friendly staff will be happy to answer any questions. You can contact us on (772) 419-0505 or fax us on (772) 781-7327.

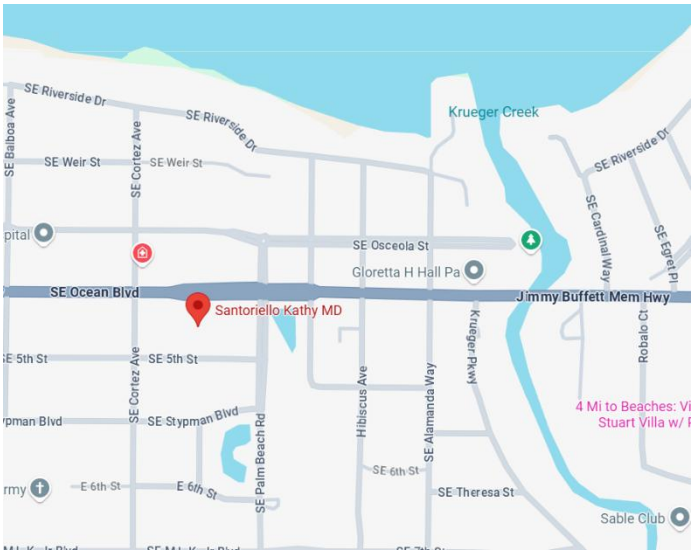
We are honored you've chosen to establish with our practice, and we look forward to meeting you.

Sincerely,

The Team at Santoriello Gynecology

Directions to our Office

We are located at **900 SE Ocean Blvd, Stuart FL 34994 in Suite # 330 in the "D" building**. We are on the **corner (near the traffic light) of Palm Beach Road and SE Ocean Blvd**. only a few miles east of downtown Stuart. We are in the middle of the complex on the 3rd floor in building D. Park where you see the awning and take the elevator near Quest to the 3rd floor and make a right to the end of the hallway to Suite #330.



NEW Patient Intake Form

Please check and/or fill in the information below and make changes as necessary:

Patient information ☐ All patient information below is correct

Name: _____ Date of Birth: _____

Address: _____

_____

Contact Phone: Cell: _____ Home: _____

Work: _____ Preferred Contact: ☐ CELL ☐ HOME

E-mail address _____

Primary Care Doctor: _____ Primary Dr Phone: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Preferred Pharmacy:

Name: _____ Phone: _____

Location: _____

Insurance Information ☐ All Insurance information below is correct

Primary Insurance Plan Name: _____

Member ID #: _____

Insured Party Name (if not self): _____ DOB: _____

Relation to Insured: _____

Secondary Insurance: ☐ YES ☐ NO

Secondary Insurance Plan Name: _____

Member ID #: _____

HIPPA/Payment Agreement Permission to discuss your health information with others (e.g. spouse, parents, children, significant others):

☐ I do not want my information discussed with anyone other than myself _____ (Please Initial)

☐ You may speak with (give names and relation):

_____ Relation to Insured: _____

_____ Relation to Insured: _____

_____ Relation to Insured: _____

Please Note: All lab, diagnostic and bone density results will be reviewed in person with a provider at your follow-up appointment

Patient Signature: _____ Date: _____

Kathy Santoriello MD PA
900 SE Ocean Blvd #330-D
Stuart FL 34994
772-419-0505

PATIENT AGREEMENT

Patient Name: _____ **Date:** _____

HEALTH INFORMATION AND COMMUNICATION: I consent to the use and disclosure of any and all protected health information about me (or the indicated under-aged minor) for treatment, payment or health care operations. This authorization is in effect now, and will remain in effect, until revoked by me in writing, dated and signed. Such revocation will not affect any disclosures already made in relation to my health care prior to revocation. Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I agree to the use of a Patient Portal by providing my email address. I understand this is NOT the office's primary form of communication. I will directly communication with the office by phone for any questions and/or concerns.

TEST ORDERS AND RESULTS: Tests ordered must be completed in a timely fashion. It is my responsibility to get the work done. I agree to a return visit with a provider to review results and develop a plan of action for all orders including labs, pathology, and diagnostic studies (ultrasounds, mammograms, bone density scan etc.). If I fail to comply, I accept responsibility for delayed diagnosis and management of my condition.

FINANCIAL AGREEMENT: I agree to pay for my care. I will provide a photo ID along with any applicable insurance cards. I agree to pay any patient financial responsibilities at the time of my visit. I am responsible for understanding the terms of my insurance policy including deductibles, co-pays, required authorizations, in/out-of-network providers and all out of pocket expenses. I authorize payment to Kathy Santoriello MD PA. A $25 late cancellation fee will be my responsibility for cancelling a visit without 24-hour notice. Emergencies happen, please call. I will be responsible for non-covered denied services and all unpaid fees for services rendered.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS: I authorize Dr Kathy Santoriello MD PA to release requested information to insurance/billing company for the purposes of billing and collection. I further authorize Kathy Santoriello MD PA send and have access to copies of any and all my medical records to/from any provider or facility for the purposes of continuity of care and medical treatment. I understand I have the right to a copy of this release, and the "Notice of Privacy Practices".

PELVIC EXAM CONSENT: I am requesting the staff at Kathy Santoriello MD PA to provide medical care as deemed appropriate for me (or the noted minor). To fulfil the new FL law, this facility is adding your signature/consent for any and all pelvic exams. Examination of private areas may or may not include use of a speculum, gynecology instruments, the examiner's hands, and/or a vaginal ultrasound probe. I am encouraged to ask questions and voice any concerns. I may decline examination.

I have read this agreement/consent and understand its terms. I am signing knowingly and voluntarily.

PATIENT SIGNATURE: _____ DATE: _____

If under 18, Responsible Party: _____Relationship to Pt: _____ DATE: _____

New Patient Check In Form

Patient Name: Date of Birth: Today's Date:

Reason for Visit: ☐ Yearly Exam ☐ Other: _____ Referring Doctor: _____

Please list what you take or use! (Medications/Vitamins/Supplements/Creams/Anything over-the-counter):

Medications (Name and Dose) Vitamins/Over-The-Counter Supplements/Creams

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: ☐ NO ☐ YES (please list) _____

REVIEW OF SYMPTOMS: Please Circle any of the following conditions you have had or now have.

Eye & Vision: loss of hearing; buzzing; infections

Nose & Throat: hoarseness; difficulty swallowing; nosebleed; frequent sneezing; thyroid disorder

Respiratory: shortness of breath; wheezing; cough; asthma; sleep apnea; Tuberculosis

Cardiovascular: chest pain; abnormal heartbeat;
swelling of ankles or feet; varicose veins; heart attack; stroke; leg clots; pacemaker, atrial fibrillation

Gastrointestinal: abnormal pain; nausea or vomiting;
loss of appetite; diarrhea; blood in stool; constipation;
weight loss; heartburn; hepatitis, fatty liver, colitis.

Urinary: urinary incontinence, urinate when coughing, blood in urine, increased frequency; painful urination, wearing pads, nightly urination.

Integumentary: itching skin, rashes, sores not healing, herpes, cold sores, shingles, skin cancers.

Musculoskeletal: joint pain or swelling, difficulty walking, neck or back pain, use of cane/walker/wheelchair.

Neurologic: headaches, dizziness, seizures, numbness or tingling, lapse of memory, blackouts

Blood: diabetes, cholesterol, high blood pressure, clotting disorder, other blood disorder.

Psychological: depression, excessive worry, severe tension, hopelessness, use of medications.

Diet: use of phenphen, use of herbs, eating disorder, swallowing trouble.

Sexual Dissatisfactory: discomfort, pain, lack of sensation, lack of interest, poor arousal.

For MA use only: Vital Signs					
HT: _____	**WT: _____**	**BP: _____**	**Temp: _____**	**RR: _____**	**Pulse: ___**
LMP: _____	SBE: ☐ YES ☐ NO				

OB/GYN History:

How many total pregnancies have you had? _____

How many preterm births (prior to 37 weeks gestation)? _____

How many abortions? _____

How many living children? _____

Around what age did you start your menstrual cycles? _____

Last Menstrual Period Date: _____ ☐ N/A Menopausal /Hysterectomy/Other _____

☐ Yes	☐ No	Are you currently on birth control? Any complications with taking birth control?(Ex: dizziness, weight gain, nausea)
☐ Yes	☐ No	Have you been vaccinated for the HPV virus?
☐ Yes	☐ No	If not, would you like information on the vaccine?

Medical History: If yes, please state issue, date of diagnosis and treatment.

☐ Yes	☐ No	Do you have a primary care physician? If yes please state name of physician
☐ Yes	☐ No	Have **you** had any history with cancer (Ex: breast, cervical, skin)? Please state type and date of diagnosis?
☐ Yes	☐ No	Have you had any breast issues?(biopsies, abnormal mammograms, fibrocystic breast, breast pain)
☐ Yes	☐ No	Have you had any cosmetic surgery?
☐ Yes	☐ No	Have you had any gynecological issues? (Ex: abnormal pap's, viruses, dryness, libido, procedures)
☐ Yes	☐ No	Have you had any cardiology issues? (Ex: murmur, cholesterol, strokes, pacemaker)
☐ Yes	☐ No	Have you had any pulmonary issues? (Asthma, Sleep apnea, tuberculosis)
☐ Yes	☐ No	Have you had any gastrointestinal issues? (GERD, procedures, constipation, Hepatitis)
☐ Yes	☐ No	Have you had any Urinary issues? (Leaking, prolapsed, procedures, kidney stones)
☐ Yes	☐ No	Have you had any endocrine issues? (Thyroid, metabolism, diabetes, procedures)
☐ Yes	☐ No	Have you had any hematology issues? (Anemia, sickle cell hyper coagulation, procedures)
☐ Yes	☐ No	Have you had any musculoskeletal issues? (Arthritis osteoporosis, knee /back, procedures)
☐ Yes	☐ No	Have you had any neurological issues? (ALS, Parkinson, neuropathy, procedures)
☐ Yes	☐ No	Have you had any psychiatry issues? (Bipolar, anxiety, depression, procedures)
☐ Yes	☐ No	Have you had any rheumatology issues? (Fibromyalgia, RH arthritis, Lupus, procedures)
☐ Yes	☐ No	Have you had any skin issues? (Acne, eczema, psoriasis, procedures)

☐ Yes	☐ No	Have you had any trauma/toxins issues? (Burns, drug overdose, motor vehicle accident, fractures, procedures)
☐ Yes	☐ No	Do you have any other medical history?

Family History:

☐ Yes ☐ No Do you have any family history of breast/ovarian/uterus cancer?
☐ Yes ☐ No Are you adopted or have unknown family history?

Mother: ☐ Living ☐ Deceased Does she have any major medical diagnosis? (heart disease, cancer, diabetes, thyroid, breast, blood pressure, cholesterol) _____
Father: ☐ Living ☐ Deceased Does he have any major medical diagnosis? (Heart disease, cancer, diabetes, thyroid, blood pressure, cholesterol) _____

Social History: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Remarried ☐ Lesbian

Please answer the following questions for the Quality Measures Database. Thank You.

Are you currently a tobacco user? ☐ YES ☐NO

If YES, How many packs a day for how long? _____
Are you ready to quit? ☐Yes ☐No
If you are ready to quit, may we refer you for smoking cessation? ☐Yes ☐ No

Do you Drink Alcohol? ☐ YES ☐ NO How many drinks do you have a day? _____
How many times in the past year have you had 4 or more drinks in a day? ☐ None ☐ 1 day ☐ more than 1 day #____

Have you received the **Flu vaccine** between Oct 1 and March 31 or previous year? ☐ YES ☐NO
Have you received the **Shingles Vaccine**? ☐ YES ☐NO
Have you ever received a **pneumococcal vaccine**? ☐ YES ☐ NO
Have you had a **Tetanus shot** (TD or Tdap vaccine).in the past 9 years? ☐ YES ☐NO
Have you ever had a bone density test **to screen for osteoporosis**? ☐ YES ☐ NO
Have you had a **mammogram** to screen for breast cancer in the past 27 months? ☐ YES ☐ NO
Have you had a **colonoscopy** to screen for colorectal cancer within the past 9 years? ☐ YES ☐ NO

☐ Yes	☐ No	Do you drink caffeine? ☐ Yes ☐ No Coffee - How many drinks do you have a day? _____ ☐ Yes ☐ No Tea - How many drinks do you have a day? _____ ☐ Yes ☐ No Soda - How many drinks do you have a day? _____
☐ Yes	☐ No	Do you follow any special diet every day? (Ex: Atkins, vegetarian) If so, what kind?

☐ Yes	☐ No	Are you sexually active? ☐ Men ☐ Women ☐ Both How many #(s) of partners had you had in the past? Do you have any history of STD's? If so, state diagnosis.
☐ Yes	☐ No	Do you regularly exercise? ☐ Cardiovascular (Ex: running,bootcamp cycling) How many times per week? ☐ Weight training (Ex: weights, calisthenics) How many times per week?
☐ Yes	☐ No	Do you use any recreational drugs? (Ex: heroin, cocaine, marijuana, pain killers) What drug you use? _____ How often do you use?
☐ Yes	☐ No	Do you have any trouble ☐ falling asleep ☐ staying asleep ☐ hot flashes?
☐ Yes	☐ No	Are you employed? If so, list job title. _____ ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student