Bethesda Health Physician Group
BAPTIST HEALTH SOUTH FLORIDA

Cari Graber Schuk, D.O., F.A.C.O.G., F.A.C.O.O.G.
Elana Deutsch, M.D., F.A.C.O.G.
Melanie Burke, D.O.,F.A.C.O.O.G.

Patient information

Last Name: _____First Name: _____Middle: _____

Preferred Name_____ Sex: Male _____Female _____ DOB: _____

SSN: _____ Race: _____Ethnicity: _____Marital Status _____

Mailing address: _____

City: _____ Zip: _____ State: _____

Phone: Home: _____Cell: _____ Work: _____

Preferred phone number: _____ Email address: _____

Emergency Contact: Name _____ Phone: _____ Relationship: _____

How did you hear about us? _____

Seasonal Patients

Out of town address: _____

City: _____ Zip: _____ State: _____

Who is your usual primary care physician?

Name: _____ Phone: _____

Address:_____

When do you come to South Florida? _____ Leave? _____

Do you have a living will or DNR form: _____ If yes, need a copy on file. (If not, we encourage you to do so; ask us for five wishes.)

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CONSENT RECORD

1. FINANCIAL AGREEMENT-I hereby guarantee payment of all charges incurred for services render by Bethesda Health Physician Group by authorized treating physician(s). Further, I guarantee payment of all attorney fees, court costs and collection charges incurred in the event collection action is initiated by Bethesda Health Physician Group.
2. MEDICARE/MEDICAID ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATIN AND PAYMENT REQUEST. I assign benefits and request that payment be made directly to Bethesda Health Physician Group. I understand that I am responsible for any deductibles and co-payments applicable.
3. USES AND DISCLOSURES OF HEALTH INFORMATION – I understand that Bethesda Health Physician Group will use and disclose my personal health information to provide treatment and process claims. This includes release of information to insurance carriers, 3rd party payers or their agents, with any right to privacy waived including any treatment for mental illness, alcohol abuse, drug abuse or HIV as may be necessary. Further, my information and medical records may be disclosed to members of the hospital's medical staff involved in my subsequent care and treatment. For details of uses and disclosures, refer to Notice of Privacy Practices.
4. CONSENT FOR GENERAL MEDICAL TREATMENT – I hereby authorize Bethesda Health Physician Group in charge of my care to administer any treatment, receive results of tests and services rendered, to administer medications deemed necessary or advisable in my diagnosis and treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments of examinations at Bethesda Health Physician Group.
5. PRIVACY PRACTICES – I have been made aware of Bethesda's Privacy practices as described in the Notice of Privacy Practices.
6. I authorized the release of any medical information necessary to process my claims. I assign benefits and request payment be made to Bethesda Health Physician Group. I permit a copy of these authorizations to be used in place of the original. I accept responsibility for all charges incurred and I am responsible for payment. Where applicable, regulations pertaining to Medicare assignment and HMO assignment of benefits apply.
7. I authorize Bethesda Health Physician Group to electronically obtain and submit immunization and medication records through the electronic portal or exchange with whom we have a relationship.

I understand that this consent is subject to revocation at any time to the extent that action has been taken in reliance thereon. I certify that I have read the foregoing, received a copy thereof, and I am the patient, the patient's legal representative or dully authorized by the patient as the patient's general agent to execute the above and accept its terms. I also fully understand the consent contained in this record and voluntarily execute it.

Patient Signature: _____ Date: _____
If other than patient, state relationship

Witness Signature: _____

PATIENT CONTACT

Contact Information*

The following people, other than duly designated guardian or conservator, are authorized to discuss my medical condition or billing information:

1._____
Name Relationship Phone Number

2._____
Name Relationship Phone Number

Print Name: _____ Date: _____

Signature: _____ Phone number: _____

***Please Note:** This contact information will remain in effect unless change is received from you in writing.

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize that my Medical Records be released from or to (circle one)

Physician Name/Clinic: _____

Address: _____

I hereby authorize that my Medical Records be released to or from (circle one) Fax: Enter fax # here

Physician Name/Clinic:_____

Address: _____

Information Requested

O For dates of service: From: _____Through: _____
O Physician notes
O Lab results
O X-ray reports
O Complete record
O Other: _____

Purpose for Use of Disclosure of Protected Health Information

O Permanent Transfer
O Referral
O Other: _____

Note: fee may be assessed for records requested for personal use

Patient Information

Printed Name: _____Date of Birth: _____SSN #: _____

SENSITIVE INFORMATION: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time; I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

ORTHER RIGHTS: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: *(If I do not specify an expiration date, event, or condition, this authorization will expire in twelve (12) months.)*

Signature of Patient or legal representative: _____

If signed by legal representative, relationship to patient: _____ Date: _____

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Appointment Cancellation/No Show Policy

Our practice is committed to providing quality healthcare to our patients. We work diligently to maintain the highest level of personalized services and make every effort to accommodate our patient's needs for visits in a timely manner.

We understand that emergencies arise, however, when a patient cancels an appointment without adequate notice or misses an appointment without any notice, we cannot use the time to service the needs of other patients. You will receive a call two days before your appointment to confirm your appointment. Failure to cancel or reschedule your appointment at least 24 hours prior to your scheduled appointment will result in the following:

- 1st occurrence: Verbal warning
- 2nd occurrence: $25 charge with additional warning of possible discharge
- 3rd occurrence: Provider can approve discharging the patient from the practice

Thank you for your consideration and understanding of our policy. Please sign below attesting that you have read and understand the cancellation/no show policy.

Patient Signature Date

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New Patient History

Welcome to our practice. Please provide us with the most accurate and thorough description of your history. This will help us to give you our best care. Thank you.

Name: _____ Date: _____

Age: _____

What is your reason for coming to see your doctor today? _____

_____

When was your last visit to the Gynecologist? _____

Your Medical History

Do you or have you had any of the following medical conditions? If yes, please provide the year you were diagnosed.

Condition	Diagnosed Date	Condition	Diagnosed Date
___ High Blood Pressure	_____	___ History of Stroke	_____
___ High Cholesterol	_____	___ History of Heart Attack	_____
___ Diabetes	_____	___ Congestive Heart Failure	_____
___ Hypothyroidism	_____	___ Depression	_____
___ Lupus	_____	___ Anxiety	_____
___ Fibromyalgia	_____	___Migraines	_____
___ Osteoporosis	_____	___History of Deep Vein Thrombosis or pulmonary embolus	_____
___ Asthma	_____	___ Cancer	_____
		If so what kind?	_____

___Other: _____

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Surgical History

What surgeries have you had in your life and what year were they performed?

Surgery	Date	Surgery	Date	Surgery	Date
___ ( ) Tonsils _____		___ ( ) Uterus removed _____		___ ( ) Tubes Tied _____	
___ ( ) Gallbladder_____		___ ( ) Uterus & ovaries _____		___ ( ) Appendix _____	
___ ( ) Hernia _____		___ ( ) Cryo/freezing of cervix_____		___ ( ) Breast Surgery _____	
___ ( ) C-section _____		___ ( ) Bladder lift _____		___ ( ) Plastic Surgery _____	
___ ( ) cone biopsy/LEEP of cervix		___( ) Hip replacement_____		___ ( ) D & C _____	

___ ( ) Other surgeries _____

Obstetrical History (If you have never been pregnant, check N/A) ○ **N/A**

How many times have you been pregnant? ____
How many vaginal deliveries have you had? ____
How many preterm deliveries have you had (delivery before 37 weeks)? ___
How many cesarean sections have you had? ____
How many miscarriages have you had? ____
How many terminations of pregnancy have you had? ___
How many living children do you have? ___

Date of Delivery	Weeks pregnant at delivery	Birth Weight	Female/ Male (M or F)	Vaginal or C-Section? (V or C)	Vacuum or Forceps? (V or F)	Did you deliver before 37 weeks of pregnancy? (Y or N)	Did you have high blood pressure, diabetes, or blood clots during pregnancy? (Y or N)	Breastfed? (Y or N)
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Gynecologic History

Do you have or have you been diagnosed with any of the following?

___ Fibroids	___ Urinary incontinence	___ Decreased sex drive
___ Endometriosis	___ Pelvic organ prolapsed	___ Ovarian cysts
___ Infertility	___ Chronic yeast infections	___ Heavy bleeding
___ Irregular periods	___ Chlamydia	___ Abnormal pap smears
___ Gonorrhea	___ Breast cysts or masses	___ Syphilis
___ Chronic pelvic pain	___ HIV	___ Hepatitis
___ Hot flashes	___ Pelvic inflammation	___ Trichomonas
___ Insomnia	___ Chronic urinary infections	___ Genital Warts
___ Vaginal dryness	___ Chronic bacterial vaginosis	
___ Postmenopausal bleeding		

- Do you use birth control now? Yes or No
  If yes, what kind? _____
- Are you on hormone therapy now for menopausal symptoms? Yes or No
  If yes, what kind? _____
- Have you ever been on Hormone therapy (ex. Pills, creams, patch)? Yes or No
  If yes, for how many years? _____

Bleeding History

- What was the first day of your last menstrual period? _____
- What age was your first period? _____ If postmenopausal, at what age was your last period? _____
- On average, how many days do/did your periods last? _____
- Do you get your period monthly? _____
- Have you ever had severe pain or heavy bleeding with your periods? _____
- Do you have bleeding or spotting after intercourse? _____
- Do you ever get more than one period in a month? _____
- Have you ever had a blood transfusion? _____
- Have you ever had any spotting or bleeding after menopause? _____

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Medications

Please list medications with dosages (including birth control, hormones, and vitamins)

○ *Check here if you brought a list/copy of your medications*

1. _____ 5._____ 9. _____

2. _____ 6._____ 10. _____

3. _____ 7._____ 11._____

4. _____8._____ 12._____

Allergies

- Do you have any allergies to ***medications***? Yes or No
  If so, what medication? _____
- Do you have any allergies to ***food***? Yes or No
  If so, what food? _____
- Do you have any allergies to ***latex*** (gloves)? Yes or No
  If so what reaction? _____

Social History

- Marital Status: Single Married Divorced Widowed
- Do you smoke? Yes or No
  If you have quit smoking, when was your quit date? _____
- Have you ever had a problem with drugs or alcohol? Yes or No
- Do you exercise? Yes or No
  How many times a week? _____
- Are you sexually active? Yes or No
  If yes, with men, women, or both? _____
- Have you been in a relationship where you were verbally or physically abused? Yes or No
- Do you have a significant concern regarding food, body image or weight? Yes or No

Family History

- Has anyone in your immediate family had breast ***cancer, colon cancer, uterine cancer*** or ***ovarian cancer***? Yes or No If yes, who? _____
- Has anyone in your immediate family had a ***blood clot*** in their legs or lungs? Yes or No
- Any family member with ***diabetes, strokes, heart attacks, thyroid disease***? Yes or No