JASMINE WOMEN'S CENTER
OBSTETRICS & GYNECOLOGY

1983 Centre Pointe Blvd • Suite 104 • Tallahassee, FL 32308 • Phone : 850-210-0433 • Fax: 850-210-0437 • JasmineWomensCenter.com

PATIENT REGISTRATION

Patient Information

Name: _____ Address:_____

Apt:_____ City:_____ Zip Code:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Social Security#:_____Date of Birth:_____ Age_____

Marital Status: Married Single Divorced Widowed E-Mail:_____

Employment Status: Employed Retired Student Other:_____

Employer: _____ Address:_____

Insurance Information

Insurance Company_____Policy#_____Group #_____

Subscriber's Name:_____ Date of Birth: _____ Relationship: _____

Secondary Insurance Information

Insurance Company_____Policy#_____Group #_____

Subscriber's Name:_____ Date of Birth: _____ Relationship: _____

Pharmacy Information

Pharmacy Name_____Phone Number _____

Address _____

NAME: _____

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Emergency Contact

Name:_____Phone#: _____ Relationship:_____

Referred by:_____Allergies to medications:_____

How did you hear about us? _____

I hereby assign all medical or surgical benefits to which I am entitled including Medicare, Private Insurance, or managed care contracts to Jasmine Women's Center OB/GYN. A photocopy of this agreement is to be valid as an original. I understand that I am financially responsible for all charges not covered by insurance. I also agree to have any medical information released to all parties in an attempt to secure insurance payment.

Signature:_____Date: _____

I also understand that if payment has not been made from my insurance company in 60 days, it will then be my responsibility to contact the insurance company and make sure payment is made in a timely manner.

Signature: _____

NAME: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of

(Name of Patient)

JASMINE WOMEN'S CENTER OB/GYN 'Notice of Privacy Practices'.

This Notice describes how **JASMINE WOMEN'S CENTER OB/GYN** may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

(Signature of Patient, or Personal Representative) (Date)

_____

(Relationship to Patient)

NAME: _____

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Consent for General Care

By signing this form, you authorize employees, including physicians, physician assistants, nurse practitioners and medical assistants of Jasmine Women's Center OB/GYN to render routine care to you during your office visits and to fulfill the orders of your physicians, including consultants, associates and assistants of Jasmine Women's Center OB/GYN Associates.

You understand that you are responsible for the total charges for services rendered, which may include services not covered by your insurance company. You agree that all amounts are due upon request and are payable to Jasmine Women's Center OB/GYN. You further understand, should your account become delinquent, you shall pay the reasonable attorney fees or collection expenses if any.

By signing this form, you consent to Jasmine Women's Center OB/GYN to release and/or disclose your medical information pertaining to mental illness (except for psychotherapy notes), use of alcohol or drugs and communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) for treatment, payment, healthcare operations, and as otherwise allowed by law.

The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Signature of Patient Legal Representative Date

Acknowledgement of
The Receipt of Notice of Health Information Practices

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Jasmine Women's Center OB/GYN is furnishing you with the attached notice, **'Notice of Privacy Practices'** which provides information about how our office may use and/or disclose protected health information about you for treatment, payment, health care operations and otherwise as allowed by law. By signing this form, you acknowledge that you have received a copy of this office's Notice of Health Information Practices.

_____ _____

Signature of Patient Legal Representative Date

NAME: _____

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Laboratory Services

Please be advised that the majority of laboratory services performed in our facility are processed through an outside laboratory. The laboratories that we currently use are Quest Diagnostics and LabCorp; these may be subject to change. Our office will collect the specimen here and forward them to the contracted laboratory along with your billing and insurance information. We determine where your specimens will be sent based upon your insurance companies' contract with each facility. Based upon your insurance policy, your benefits may vary for laboratory services. All billing of laboratory services will be handled by the specific laboratory used. For any out-of-pocket expenses or billing disputes, please contact the laboratory directly.

Normally when Pap Smears are read at a laboratory, they are read by a Cytotechnologist. If there are any abnormalities found in the review of the Pap Smear, it may be forwarded to a physician who then reviews and interprets the Pap Smear again. This ensures that a precise reading had been performed and that the results are as accurate as possible. If a laboratory physician is required to review your Pap Smear, there will be an additional charge of $16.00 to $20.00 added to your account that may not be reimbursable based on your insurance plan. In the event that you are charged this additional fee, you will receive a bill from our office or from the laboratory.

By signing below, you state that you understand the above statements and agree to pay the laboratory bill to them separately.

_____ _____
Patient Signature Date

Consent to Treat a Minor

_____, (Minor Child) has an appointment at Jasmine Women's Center OB/GYN, on _____(Date) for an examination and treatment.

I,_____(Parent/Guardian) give Jasmine Women's Center OB/GYN my permission to examine and treat the above named child.

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Patient Name:_____Date of Birth_____

Reason for Visit

What brings you in today?_____

What other concerns would like to address?

Current Medications

What medications are you taking?_____

Name	Dose	Frequency

Allergies

Are you allergic to: ☐ Tape ☐ Latex ☐ Iodine

Name	Reaction

Past Medical History

☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Anxiety
☐ Asthma
☐ AIDS/HIV
☐ Autoimmune Disorders
☐ Back problems
☐ Bleeding
☐ Blood Disorders
☐ Blood Transfusion
☐ Breast Cancer
☐ Clotting Disorder
☐ Colon Cancer
☐ Diabetes
☐ Depression
☐ Eating Disorders
☐ Ear Problems
☐ Epilepsy
☐ Glaucoma
☐ Gout
☐ Heart Disease
☐ Heart Defects
☐ Hepatitis A,B, or C
☐ High Blood Pressure
☐ High Cholesterol
☐ Liver Disorder
☐ Kidney Disorder
☐ Joint Disorder
☐ Lung Disorder
☐ Measles
☐ Migraines
☐ Osteoporosis
☐ Pneumonia
☐ Polio
☐ Psychiatric Illness
☐ Rheumatic Fever
☐ Stroke
☐ Thyroid Disorder
☐ Stomach Ulcer
☐ Substance Abuse
☐ Skin Disorder
☐ Tuberculosis
☐ Sexually Transmitted Disease

Other details:

Patient Name:_____Date of Birth_____

Family Medical History

☐ Alcoholism	☐ Breast Cancer	☐ Hepatitis A,B, or C	☐ Psychiatric Illness
☐ Allergies	☐ Clotting Disorder	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Anemia	☐ Colon Cancer	☐ High Cholesterol	☐ Stroke
☐ Anxiety	☐ Diabetes	☐ Liver Disorder	☐ Thyroid Disorder
☐ Asthma	☐ Depression	☐ Kidney Disorder	☐ Stomach Ulcer
☐ AIDS/HIV	☐ Eating Disorders	☐ Joint Disorder	☐ Substance Abuse
☐ Autoimmune Disorders	☐ Ear Problems	☐ Lung Disorder	☐ Skin Disorder
☐ Back problems	☐ Epilepsy	☐ Measles	☐ Tuberculosis
☐ Bleeding	☐ Glaucoma	☐ Migraines	☐ Sexually Transmitted Disease
☐ Blood Disorders	☐ Gout	☐ Osteoporosis	
☐ Blood Transfusion	☐ Heart Disease	☐ Pneumonia	
	☐ Heart Defects	☐ Polio	

Other details:_____

_____

_____

Past Surgical History

Surgery	Date	Where Performed
Surgery	Date	Where Performed
Surgery	Date	Where Performed
Surgery	Date	Where Performed

Lifestyle

Are you sexually active? ☐ Yes ☐ No How many partners? (past year)_____ (total lifetime)_____

If not currently active, have you ever been sexually active? ☐ Yes ☐ No

Sexual Partner(s) is/are: ☐ Male ☐ Female ☐ Both

Would you like to be checked for sexually transmitted diseases? ☐ Yes ☐ No

Has anyone in your home physically or verbally hurt you? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No packs/day_____ Have you ever smoked? ☐ Yes ☐ No Quit Date_____

Do you use recreational drugs? ☐ Yes ☐ No What types/Frequency_____

How much alcohol do drink per week?_____

How much caffeine do you drink per day?

How many times per week do you exercise?_____

Patient Name:_____Date of Birth_____

Pregnancy History

# pregnancies	#term	#preterm	#miscarriages	#abortions

Date	#Weeks	Type of Delivery	M/F	Weight	Living	Complications

Are you currently pregnant? ☐ Yes ☐ No

Are you trying to become pregnant? ☐ Yes ☐ No

What is your current method of birth control? ☐ N/A ☐ Abstinence ☐ Condoms

☐ Intrauterine Device ☐ Implanon/Nexplanon ☐ Vaginal Ring (Nuva Ring) ☐ Contraceptive Patch

☐ Spermicide ☐ Natural Family Planning/Rhythm Method ☐ Withdrawal ☐ Diapragm/cervical cap

☐ Oral contraceptive Pills: (name)_____ ☐ Other:_____

Menstrual History

Age at first period?_____

Date of last period?_____

Frequency of periods?_____

Length of period?_____

Are your periods regular? ☐ Yes ☐ No

Age at menopause?_____

Health Maintenance

Last pap smear _____

Last mammogram _____

Last colonoscopy _____

Last bone density _____

Last general health checkup _____

Immunizations up to date? ☐ Yes ☐ No

OB/GYN History

☐ Abnormal vaginal bleeding
☐ Abnormal pap smear
☐ Bleeding between periods
☐ Breast Lump/Mass
☐ Breast Cancer
☐ Breast Surgery
☐ Cervical Cancer
☐ Cervical Dysplasia
☐ Chlamydia
☐ Colposcopy previously
☐ Cryosurgery
☐ DES exposure
☐ Fecal/Flatus Incontinence
☐ Fibroids
☐ Genital Warts
☐ Gonorrhea
☐ Herpes
☐ Hot Flashes
☐ HPV (Human Papilloma Virus)
☐ Infertility
☐ Irregular Periods
☐ Menstrual Pain
☐ Nipple Discharge
☐ Ovarian cysts
☐ Ovarian Cancer
☐ Painful Intercourse
☐ Pelvic Infl. Disease
☐ Uterine Cancer
☐ Uterine Hyperplasia
☐ Urinary Incontinence
☐ UTI – frequent
☐ Vaginitis (BV) – frequent
☐ Yeast - frequent