CONFIDENTIAL PATIENT PROFILE

Last Name: _____
First Name: _____ MI: ____
Address: _____
_____
City: _____
State: _____ Zip: _____
Phone #1 (H/W/C): _____
Phone #2 (H/W/C): _____
Phone #3 (H/W/C): _____
Employer: _____

Date of Birth: _____
Marital Status: _____
Social Security Number: _____
Race / Ethnicity: _____
Primary Doctor: _____
Referring Doctor: _____

Student status: ___ Full time
___ Part time
___ Not a student

**** We are happy to introduce *PATIENT PORTAL*****
Through your email address, you can access the office online to obtain lab results, contact the staff and receive appointment confirmations. This avoids a lot of telephone calls and excess paperwork in addition to quick turn around time on our responses. **All we need is your email address:** _____

Spouse / Significant Other: Name: _____ Telephone/Cell: _____

Emergency Contact:
Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ zip: _____
Home Phone: _____ Work/Cell phone: _____ ext. _____

Responsible party for claims payment: ___ Self __ Other(Name: _____)
Circle how you heard of us: Friend Advertisement Physician Internet Insurance Company
Preferred Pharmacy: _____ Telephone: _____

Please list:
Surgeries (include year): _____
_____
Medications& strengths:_____
_____
Medication Allergies:_____
Medical problems not listed below:_____
Pregnancy History: Number of pregnancies: _____ Abortions: _____ Miscarriages: _____ Ectopic: _____
Deliveries: Full term: _____ Preterm: _____ Twins: _____ Living Children: _____

Patient's Medical History

Have YOU ever had:	Circle:	Detail Yes Remarks	Have YOU ever had:	Circle:	Detail Yes Remarks
Diabetes	Yes No		Hepatitis/Liver Disease	Yes No	
Hypertension	Yes No		Bleeding Disorder, Hemophilia	Yes No	
Heart Disease	Yes No		Thyroid Disease	Yes No	
Rheumatic Fever	Yes No		Urinary Tract Infections	Yes No	
Mitral Valve Prolapse	Yes No		Asthma/Respiratory Disease	Yes No	
Kidney Disease	Yes No		Abnormal Pap	Yes No	
Nervous/Mental Disorders	Yes No		Anesthesia Complications	Yes No	
Epilepsy/Seizures	Yes No		Breast Problems	Yes No	
Sexually Transmitted Diseases: Chlamydia, Gonorrhea, Herpes, etc	Yes No		Common Childhood Diseases: Chickenpox, Measles, Mumps	Yes No	

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6440 West Newberry Road, Suite 111, Gainesville, FL 32605, Telephone (352) 331-3332, Fax: (352) 331-3320
4447 NW American Lane, Lake City, FL 32055, Telephone (386) 754-1744, Fax: (352) 331-3320

Patient Name: _____ Date: _____

Genetic Screening Questionnaire

	Yes	No	Relationship to this baby
1. Please explain if you or the baby's father or anyone in either of your families has ever had any of the following conditions:			
a. Down's syndrome			
b. Spina bifida or spinal cord defect			
c. Hemophilia or bleeding disorder			
d. Muscular dystrophy			
e. Cystic Fibrosis			
*f. Tay Sachs disease			
†g. Sickle cell disease			
‡h. Thalassemia			
i. Mental retardation. Explain cause if known:			
j. Other genetic disorder. Please describe:			
k. Other birth defect. Please describe:			
l. Three or more miscarriages			
2. Please explain if you or the baby's father have any close relatives with the following ethnic backgrounds:			
*a. Ashkenazi (Eastern European) Jews			
†b. African			
‡c. Mediterranean (Greek, Italian)			

3. How old will you be when the baby is born? _____

4. Have you used any medication or drugs during this pregnancy?

5. Are there any other medical, genetic, or family considerations about which we should know

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All About Women
Obstetrics & Gynecology
Anthony B. Agrios, MD
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K. Nicole Scogin, MD
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INFORMED CONSENT TO ABIDE BY PRIVACY PRACTICES

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information. I have been given an opportunity to review the policies therein, and I agree to its stipulations. If I have any specific restrictions for my personal health information, I will submit them in writing.

_____
Name of Patient or Personal Representative

Date of Birth_____

X_____
Signature of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority (if not Patient)

PERMISSION TO RELEASE MY INFORMATION TO FAMILY AND LOVED ONES

I permit release of my personal health information to the following individuals by telephone, mail, or fax. This authorization will persist until I revoke it in writing.

Husband: _____

Parent: _____

Children: _____

Others: _____

Others: _____

X_____
Signature of Patient or Personal Representative

_____
Date

PATIENT RESPONSIBILITY FOR PAYMENT FOR SERVICES RENDERED

I. **PRIMARY INSURANCE –**

a. **My primary insurance is: _____**

b. **I have secondary insurance: (Circle one) YES OR NO**

i. **IF YES, name the secondary insurance _____**

c. **Name of Policy Holder: _____**

d. **Policy Holder Date of Birth: _____**

e. **Patient relationship to Policy Holder: _____**

II. **PHYSICIAN INSURANCE ASSIGNMENT** - I, the below named subscriber, 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.

III. **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 Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for a Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. **COPIES OF AUTHORIZATIONS** - I permit a copy of these authorizations and assignments to be used in place of the original which is on file at the physician's office.

V. **RESPONSIBILITY FOR PAYMENT** - I agree that should the amount of the insurance benefits be insufficient to cover the expenses, I will be responsible for payment of the difference in accordance with the agreement between All About Women and my insurance carrier. I will be responsible for the entire amount due for professional services rendered if the expense is not covered by my policy. I also understand that, if required, some specimens must be sent to an outside lab for testing. For example, all pap smears are sent to an outside lab for testing. I agree that I am responsible for paying all fees associated with that testing and I understand that I will be billed directly by the lab performing the testing procedure should my insurance benefits be insufficient to cover the expenses.

VI. **LATE FEES** - I understand that payment for professional services is due when said services are rendered. Unless other arrangements are made in advance, I agree to pay all amounts not payable by insurance immediately when billed. All amounts not paid within 30 days of the billing date may be assessed monthly late fees in the amount of $1.00 or 1½ % of the outstanding balance, whichever is greater. If I fail to pay all amounts due in a timely manner, I agree to pay all costs incurred for collection including reasonable attorney's fees, whether a lawsuit is filed or not.

X_____
Signature of Patient or Personal Representative

_____
Date

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Cancellation/No Show Policy

As part of our continued effort to provide you with the best care and accommodate all appointment requests, we have implemented a cancellation policy.

Time has been specifically reserved for your treatment. If you need to reschedule or cancel, Please call our office **at least 48 hours prior** to your scheduled appointment so that we may offer that appointment time to another patient in need.

If you fail to call our office at least 48 hours prior to your appointment you will be charged a **$35 Cancellation/No Show fee**. This fee is not covered by insurance and is the sole responsibility of the patient.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. If you have questions about the cancellation policy or the fee, please call our office at 352-331-3332.

Please sign that you have read, understand, and agree to this cancellation and no show policy.

Patient Name (Please Print) _____ Date of Birth_____

Signature _____ Date_____

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