**NEW BEGINNINGS OB/GYN, PA**
**336 N. BABCOCK ST. STE 101**
**MELBOURNE, FL 32935**
**PHONE (321)775-1470**
**FAX (321)775-1480**

## DEMOGHRAPHICS

Name: _____Date of Birth: ____/_____/____AGE:____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: ( ) _____Cellular Phone :( )_____
Social Security Number: _____
**E-mail:** _____ _____Marital Status: __Single __Married __Divorced __Widowed
Employer: _____Occupation:_____
Work Phone: _____Extension:_____
Spouse/significant other: _____Phone :( )_____
Emergency contact: _____ Phone :( )_____
Referred to practice by: _____ _____
Primary Care Provider: _____Phone :( )_____ Fax :( )_____
Pharmacy: _____Phone :( )_____
Primary Language Spoken: _____ DO you have a living will? _____

## INSURANCE INFORMATION

Primary: _____
ID#:_____
Group#:_____
Claims Address: _____
_____
Subscriber: Spouse Self Dependent
Name of subscriber: _____
Subscriber's SSN/ DOB: _____

Secondary_____
ID#:_____
Group #:_____
Claims Address: _____
_____
Subscriber: Spouse Self Dependent
Name of subscriber: _____
Subscriber's SSN/DOB: _____

**AUTHORIZATION TO PAY BENEFITS TO PHYSICAIN**: I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for her services as described. Realizing I am responsible to pay non covered services.

**SIGNATURE: _____** **DATE: _____**

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize New Beginnings OB/GYN to release information acquired in the course of my treatment necessary to process insurance claims.

**SIGNATURE: _____** **DATE: _____**

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# CONTACT FORM

Name: _____ DOB: ___/___/___ Date:___/___/___

Email address: _____

Do we have permission to?

Call your home: yes_____ NO_____ Call your work: yes_____ NO_____

**Can we leave information on your voice mail/ email in regards to?**

Appointments: YES_____NO_____
Billing /financial YES_____NO_____
Medical/results YES_____NO_____

**I Give permission to share information with persons listed below:**

Name: _____ Relationship: _____

Appointments: YES_____NO_____
Billing /financial YES_____NO_____
Medical/results YES_____NO_____

Name: _____ Relationship: _____

Appointments: YES_____NO_____
Billing /financial YES_____NO_____
Medical/results YES_____NO_____

Name: _____ Relationship: _____

Appointments: YES_____NO_____
Billing /financial YES_____NO_____
Medical/results YES_____NO_____

SIGNATURE: _____ DATE: _____

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## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW CAREFULLY.

If you have any questions about this notice, please contact:
New Beginnings OB/GYN, PA
336 N. Babcock St. Ste 101, Melbourne, Fl
(321)-775-1470

I understand that as part of my health care, New Beginnings OB/GYN, PA, generate and maintain health records that describe my health history, test results, diagnosis, examination, and treatment. This information is used:

1. **TREATMENT:** Your PHI will be used as a means to plan your treatment and care plan, this include communication with other healthcare providers that are involved with your care.

2. **PAYMENT:** Your PHI will be used as a source of information for applying diagnosis and surgical information to my bill

3. **OPERATION**: We may disclose your PHI to third party payer as means to conduct the operation of the office. ie with our billing company to verify billed/provided services, contacting you by phone or email, mailing reminder cards to your home. We may also post picture you provided to us in our office

4. **REQUIRED BY LAW**: We may also disclose your PHI if required by law. Ie reporting communicable disease to health department, for quality assurances purposes, public health, legal proceedings, and law enforcement.

Your Health Information Rights:

1. Obtain a paper copy of this notice of Privacy Pplicies upon request
2. Inpsect and copy your health record as provided for in the statue
3. Amend your health record as provided for in the statue
4. Obtain an accounting of disclosures of your health information
5. Request communications of your health information by alternative means or at alternative locations
6. Request a restriction on certain uses and disclosure of your information as provided fro by statue
7. Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Resposibilities:

1. Maintain the privacy of your health information
2. Provide you with this notice as to our leagl duties and privacy practices as it relates to the information we maintain about you
3. Abide by the terms of tthis notice
4. Notify you if we are unable to agree to a requested restriction
5. Accomodate reasonable requests for communications of your health information by alternative means/location

Except for the above stated purposes we will only disclose your health information with your written permission. This can be revoked by you at anytime. You may revoke such permission by sending New Beginnings OB/GYN, P.A., a written notice.

If you have questions or would like additional information please contact our privacy officer, Pat Schaad, at 321-775-1470.

If you believe your privacy rights have been violated, you can file a complaint with our privacy officer or with the Office for Civil Rights.

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Room 509F,HHH Building
Washington, D.C. 20201

Signature: _____ Date: _____

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# PRACTICE POLICY

Thank you for choosing New Beginnings obgyn as your healthcare provider. We look forward to assisting you in improving and maintaining your health so that you can enjoy a high quality and productive life. We cherish our relationship with you. These are standard policy set in place to facilitate your care.

**Your Appointment:**

We see patients by appointments only. Routine and annual appointments are generally scheduled weeks/months in advance. Urgent appointments are seen within one-two days. Emergency are seen immediately. To facilitate the ease of your appointment, we have placed a number of forms on our website; please fill out prior to your visit. Please also ensure that you have your driver's license, and insurance card.

**Minors/Dependent:**

Children under the age of 18, unless pregnant, will require the signature of parent or legal guardian prior to being seen by the physician.

**Prescriptions:**

Requests for prescription refills are renewed during normal business hours (Monday-Friday, 9:00-4:30pm). You can have your pharmacy fax us a request. Please allow 48 hours for completion. At times we may require you to be seen prior to filing of a prescription. Narcotics will not be faxed or called in.

**Missed/Cancelled Appointments:**
It is the policy of the office to confirm appointments two-three days in advance. If a patient fails to show for their confirmed appointment or elects to call the day of the appointment to cancel or reschedule, the patient will be charged $25.00. If this is done on a repetitive basis then the patient may be discharged from the practice.

**Late Policy:**
If a patient is more than ten minutes late for their appointment they will be rescheduled at the discretion of the of the physician

**Financial Responsibility**: Please be prepared to pay your deductible, co-pays, co-insurance or outstanding balances prior to seeing the physician. All claims will be submitted to insurance. If you are a self pay patient,

payment is due at the time of service. Any product ordered specifically for you will require that you leave a valid credit card on file prior to the ordering of that product. We accept all major credit cards, cash, and check. Payment from statement is due upon receipt of statement. All billing issues are addressed by the billing department, not the physician. All accounts that are past due or delinquent will be managed directly by the billing company in the manner which is customary.

**Medical Records**: If desired**,** copies will be sent to primary provider at no charge. Copies to other physicians will cost $1.00 per page for the first 25 pages and $0.25 per page for each additional page. Payment is required prior to the transfer of records.

Name:_____ Date:____/____/____

Signature:_____ Date:____/____/____

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# ANNUAL RETURN VISIT

NAME: _____ DATE: _____/_____/_____ Date of Birth: _____/_____/_____

Reason for today's visit: _____

Date last period began: _____ Allergies: _____

How many times have you been pregnant? _____ How many children do you have? _____

**What do you do to avoid pregnancy? Please check one:**

| YOUR GYN HISTORY | | | | | |
|---|---|---|---|---|---|
| | YES | NO | | YES | NO |
| Do you use Birth Control | | | Nuvaring | | |
| Condoms | | | Orthoevira Patch | | |
| Depo Provera | | | Implanon | | |
| Diaphragm | | | Tubal Ligation | | |
| IUD-Kind | | | Vasectomy | | |
| Mirena | | | Natural family Planning | | |
| Paraguard | | | Contraceptive Foam/Jelly | | |
| Date Inserted:_____ | | | | | |
| Birth Control Pill | | | | | |
| Name:_____ | | | | | |
| Menapause | | | | | |
| What age:_____ | | | | | |
| | | | | | |

Current medication (please include dosage): _____

Date of Last Mammorram : _____/_____/__ Date of Last Colonoscopoy: _____

Date of Last Bone Density Test: _____/_____/_____

Do you have a history of breast, ovarian, or colon cancer (if yes give details):

Have you had abnormal pap in the last 5 years? (If yes, what type of treatment or follow up did you have for this):

Please describe any changes in personal, social, or health status since your last visit here:

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NAME: _____ DATE: _____/_____/_____ Date of Birth: _____/_____/_____

**FILL OUT FOR ANNUALS ONLY**

Review of System

Please Check (x) if any of the following applies to you now

| | | | |
|---|---|---|---|
| **Constitutional** | | **Genitourinary** | |
| Weight Loss | ☐ | Urgency of Urination | ☐ |
| Weight Gain | ☐ | Frequency of Urination | ☐ |
| Fever | ☐ | Pain with Urination | ☐ |
| Fatigue | ☐ | Night Time Urination | ☐ |
| Night Sweats | ☐ | Losing Urine | ☐ |
| Hot Flash | ☐ | Blood in Urine | ☐ |
| **Eyes** | ☐ | Decreased sex drive | ☐ |
| Double Vision | ☐ | Painful Intercourse | ☐ |
| Vision Change | ☐ | Possible Pregnancy | ☐ |
| **Hent** | | Genital Scores | ☐ |
| Headaches | ☐ | Vaginal Discharge | ☐ |
| Dizziness | ☐ | **Skin** | |
| Sore Throat | ☐ | Rash | ☐ |
| Sinus Pain | ☐ | Itching | ☐ |
| Nose Bleeding | ☐ | Skin Dryness | ☐ |
| Thyroid Mass | ☐ | Skin Lesions | ☐ |
| Neck Pain | ☐ | Changes to Lesions or Moles | ☐ |
| **Breast** | | Acne | ☐ |
| Lumps | ☐ | **Neurological** | |
| Tenderness | ☐ | Muscular Weakness | ☐ |
| Swelling | ☐ | Numbness or Tingling | ☐ |
| Discharge | ☐ | Difficulty Concentrating | ☐ |
| Pain in Breast | ☐ | Memory Difficulties | ☐ |
| Abnormal Changes in Breast | ☐ | Speech Difficulties | ☐ |
| **Cardiovascular** | | Seizures | ☐ |
| Chest Pain | ☐ | Loss of Balance | ☐ |
| Irregular Heart Beats | ☐ | Musculoskeletal | ☐ |
| Rapid Heart Beats | ☐ | Joint Pain or Swelling | ☐ |
| Fainting | ☐ | Muscle Pain | ☐ |
| Swelling of Legs | ☐ | Back Pain | ☐ |
| Varicose Veins | ☐ | **Endocrine** | |
| Respiratory | ☐ | Loss of Hair | ☐ |
| Wheezing | ☐ | Difficulty Tolerating Cold | ☐ |
| Cough | ☐ | Difficulty Tolerating Heat | ☐ |
| Shortness of Breath | ☐ | Psychiatric | ☐ |
| Spitting up Blood | ☐ | Anxiety | ☐ |
| **Gastrointestinal** | | Depression | ☐ |
| Nausea | ☐ | Impulsive Behavior | ☐ |
| Vomiting | ☐ | Suicidal Thoughts | ☐ |
| Diarrhea | ☐ | Excessive Anger | ☐ |
| Constipation | ☐ | Mood Swings | ☐ |
| Abdominal Pain | ☐ | Emotional Abuse | ☐ |
| Bloody/Black Stool | ☐ | Physical Abuse | ☐ |
| Hemorrhoids | ☐ | Sexual Abuse | ☐ |
| Jaundice | ☐ | **Allergic/Immunologic** | |
| **Hematologic/Lymphatic** | | Frequent Illness | ☐ |
| Bruises Frequently or easily | ☐ | Seasonal Allergies | ☐ |
| Cuts Do Not Stop Bleeding | ☐ | Other | ☐ |
| Enlarge Lymph Nodes | ☐ | 1 | ☐ |
| | | 2 | ☐ |
| | | 3 | ☐ |

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Date:____/____/____

In the event that my primary care physician does not send a referral and my insurance does not cover my appointment, I understand and accept responsibility for the appointment and I understand that I will be billed for the appointment.

Patient Signature:_____ Date:____/____/____

Patient Name(print):_____

Witness:_____ Date:___/____/____