

# Palm Beach Obstetrics & Gynecology, LLC

Please print and complete as accurately as possible

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Marital Status:  Single  Married  Divorced  Widowed  Other

Permanent Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security No. \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Mo Day Yr

Ethnicity:  Hispanic  Not Hispanic

Race:  White  African-American  Asian  Amer Indian/Alaskan  Pacific islander  Other

E-mail address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Pharmacy name: \_\_\_\_\_ City: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Preferred communication:  E-mail  Phone  Text  Mail

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

## EMPLOYER INFORMATION

Name of Employer: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

## INSURANCE INFORMATION

Insurance: \_\_\_\_\_

Claims Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policyholder name: \_\_\_\_\_

Policyholder Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security No. \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Mo Day Yr

Does your insurance require a referral?  Yes  No

# Palm Beach Obstetrics & Gynecology, LLC

## Release of information

### MEDICAL RECORDS RELEASE

I authorize the release of any medical information necessary to process any insurance claim(s). I permit a copy of this authorization to be used in place of the original.

The following person can have access to my medical information:

\_\_\_\_\_

Relationship to patient: \_\_\_\_\_

OR

Do not leave me a message or release information to anyone. Speak directly with me before releasing medical information.

By signing this authorization, I understand that medical records/lab results released may contain information related to HIV status, AIDS, sexually transmitted diseases and other personal information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### CONSENT FOR TREATMENT

I authorize, request and consent for the performance of office procedures deemed necessary by the physicians and their staff.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If the patient is less than 18 years of age,

\_\_\_\_\_  
Signature of parent or guardian

Relationship: \_\_\_\_\_

Please be advised that some procedures require a specimen to go to the lab for analysis. These procedures include PAP smears, biopsies and blood samples. Our office will not charge you for these services. The lab will bill you or your insurance directly.

# Palm Beach Obstetrics & Gynecology, LLC

## Financial Policy

The following information is provided to make our financial policies clear and avoid any possible misunderstandings concerning the payment for professional services.

### Insurance

Our practice participates in a variety of insurance plans. It is your responsibility to:

- Bring your Insurance Card to every visit
- Be prepared to pay for any co-pays and deductibles that apply
- Payment in full is due at the time of service for any medical care not covered by your insurance. You are responsible for any balance if your insurance denies all or part of the claim.

### Self-Pay patients

- Payment for office visits is due at the time of service
- A payment plan is available for obstetrical care and for surgical procedures. Please ask to speak with our Administrator for details.

### Referrals

It is the patients responsibility to bring any required referrals for treatment at the time of the visit. If a referral is not available, the appointment may have to be rescheduled.

### Lab fees

Please be aware that lab fees for blood work and pathology(including PAP smears) are separate from our office charges and may be billed directly to you by the lab company.

Insurance coverage is complicated and each policy is different. If you have any questions about your insurance, we are happy to help you. However, details about your particular coverage must be directed at your Insurance Company's Member Services Department. Their number is usually found in the back of the insurance card.

## ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Palm Beach Obstetrics & Gynecology LLC for services rendered. I understand that I am responsible for all charges not covered by my medical insurance. In addition, I am responsible for any deductible, co-pay and co-insurance amounts.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Palm Beach Obstetrics & Gynecology LLC

Samuel Lederman MD, Gloria Hakkarainen MD, Sylvia Siegfried MD,  
Joy Cavalaris MD, Lori Sevald MD, Marcela Lazo MD,  
Barbara Telan CNM

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

By signing this form, I acknowledge that I have read this form, that I fully understand its contents, and that I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

# Palm Beach Obstetrics & Gynecology LLC

## Summary of Privacy Practices

(A copy of the complete "Notice of Privacy Practices" is available upon request or by calling 561.434.0111)

### Our Privacy Practices

In the course of providing healthcare services to you, we may use and disclose your protected health information to carry out **treatment**, to pursue **payment**, for **health care operations at our facilities** and for other purposes that are **permitted or required by law**.

"Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

#### Some of the ways that we may use your information could include the following:

- Appointment Reminders
- To Discuss Treatment Alternatives
- Health-Related Benefits and Services
- Fundraising Activities
- Hospital Directory
- Individuals Involved in a Patient's Care or Payment for a Patient's Care
- Clinical trials
- As Required By Law
- To Avert a Serious Threat to Health or Safety

#### In the following special situations we may also be required to use or disclose your health information:

- Organ and Tissue Donation
- Military and Veterans
- Workers' Compensation
- Public Health Risks
- Health Oversight Activities
- Lawsuits and Disputes
- Law Enforcement
- Coroners, Medical Examiners and Funeral Directors
- National Security and Intelligence Activities
- Inmates

Palm Beach Obstetrics & Gynecology LLC works closely with several allied companies to provide comprehensive care to our patients. Demographic and medical information may be shared with Palm Beach Weight & Wellness, Laser Skin Solutions or Altus Research to make our patients aware of new treatments, products or services that may impact their health.

Other uses and disclosures of medical information not covered by our Notice of Privacy Practices or the laws that apply to us will be made only with a patient's written permission.

### Patient Rights

**Patients have the following rights regarding medical information maintained by Palm Beach Obstetrics & Gynecology LLC**

- Right to Request Restrictions on who has access to information
- Right to Receive Confidential Communication
- Right to Inspect and Copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to a Paper Copy of the Palm Beach Obstetrics & Gynecology LLC Notice of Privacy Practices
- Right to File a Complaint

*Patients will not be penalized for filing a complaint. Palm Beach Obstetrics & Gynecology LLC is committed to protecting an individual's rights under the Health Insurance Portability and Accountability Act ("HIPAA") and at no point will require an individual to waive their right to file a complaint as a condition of the provision of treatment.*

### Important Contact Information

#### Palm Beach Obstetrics & Gynecology LLC

Darlenys Franco, Privacy Officer  
4671 S Congress Avenue, Suite 100-B  
Lake Worth, FL 33461  
561.434.0111

#### U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR)

Voice Phone 404.562.7886  
FAX 404.562.7881  
<http://www.hhs.gov/oc>

By signing this form, I acknowledge that I have been made aware of the Palm Beach Obstetrics and Gynecology LLC's "Notice of Privacy Practices" and was offered a copy. I understand I am not required to sign this authorization.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_

Effective Date: March 3<sup>rd</sup>, 2012

**Palm Beach Obstetrics & Gynecology LLC**  
**Personal History-Gynecology**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

This part of the medical record is strictly confidential. It will not be released to any other person or entity without your written authorization.

**1. Past Medical History:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Vaginal warts                 | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Sexually transmitted diseases | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Uterine fibroids              | <input type="checkbox"/> Psychiatric problems |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Abnormal PAP smears           | <input type="checkbox"/> Thyroid disease      |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> PMS                           | <input type="checkbox"/> Irritable bowel      |
| <input type="checkbox"/> Leg blood clots     | <input type="checkbox"/> Genital Herpes or blisters    | <input type="checkbox"/> Stomach ulcers       |
| <input type="checkbox"/> Lung blood clots    | <input type="checkbox"/> Oral Herpes or blisters       | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Blood transfusions  | <input type="checkbox"/> Osteoporosis                  | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Endometriosis                 | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Skin cancer         | <input type="checkbox"/> Bladder infections            | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Skin fungus         | <input type="checkbox"/> Kidney problems               | <input type="checkbox"/> Radiation treatment  |
| <input type="checkbox"/> Other skin problems | <input type="checkbox"/> Bone fractures                | <input type="checkbox"/> Sickle cell disease  |
| <input type="checkbox"/> Breast cancer       | <input type="checkbox"/> Other cancer (type) _____     |   |

Other \_\_\_\_\_

**2. Surgeries:**

None

- |   | Year  |                                       | Year  |   | Year  |
|---|-------|---------------------------------------|-------|---|-------|
| <input type="checkbox"/> Hysterectomy     | _____ | <input type="checkbox"/> C-Section    | _____ | <input type="checkbox"/> Tubal ligation | _____ |
| <input type="checkbox"/> Appendix removal | _____ | <input type="checkbox"/> Gallbladder  | _____ | <input type="checkbox"/> D&C            | _____ |
| <input type="checkbox"/> Tonsil removal   | _____ | <input type="checkbox"/> Knee surgery | _____ | <input type="checkbox"/> Breast biopsy  | _____ |
| <input type="checkbox"/> Cosmetic surgery | _____ | Type _____                            |       |   |       |
| <input type="checkbox"/> Other            | _____ |                                       |       |   |       |

**3. Medications:**  None

- |  | Name/Dose |                                   | Name/Dose |
|--|-----------|-----------------------------------|-----------|
| <input type="checkbox"/> Birth control pills | _____     | <input type="checkbox"/> Heart    | _____     |
| <input type="checkbox"/> Blood pressure      | _____     | <input type="checkbox"/> Hormones | _____     |
| <input type="checkbox"/> Thyroid             | _____     | <input type="checkbox"/> Vitamins | _____     |
| <input type="checkbox"/> Aspirin             | _____     | <input type="checkbox"/> Insulin  | _____     |
| <input type="checkbox"/> Other               | _____     |                                   |           |

**4. Allergies:**

None

- |                                       |                                |                                       |
|---------------------------------------|--------------------------------|---------------------------------------|
| <input type="checkbox"/> Penicillin   | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Tape         | <input type="checkbox"/> Latex | <input type="checkbox"/> Foods        |
| <input type="checkbox"/> Other: _____ |                                |                                       |

**5. Family history:**

Unknown

Parents, grandparents and siblings only

Please write which family member next to diagnosis

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Cervical cancer           | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> Uterine cancer            | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Leg or lung blood clots |
| <input type="checkbox"/> Ovarian cancer            | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Colon cancer            |
| <input type="checkbox"/> Breast cancer             | <input type="checkbox"/> Sickle cell         | <input type="checkbox"/> Mental illness          |
| <input type="checkbox"/> Osteoporosis              | <input type="checkbox"/> Kidney problems     | <input type="checkbox"/> Genetic problems        |
| <input type="checkbox"/> Other cancer (type) _____ |  |  |
| <input type="checkbox"/> Other _____               |  |  |

**6. Menstrual history:**

In menopause  Yes  No Age of menopause: \_\_\_\_\_

If already in menopause, please go to section 8

Age of first period: \_\_\_\_\_ Number of bleeding days: \_\_\_\_\_

Days between periods: \_\_\_\_\_

Flow:  Light  Medium  Heavy  None

Date of last menstrual period: \_\_\_\_\_

**7. Contraception:**  None

- |   |                                      |                                     |
|---|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Tubal ligation                   | <input type="checkbox"/> Vasectomy   | <input type="checkbox"/> Rhythm     |
| <input type="checkbox"/> Condoms                          | <input type="checkbox"/> Foam        | <input type="checkbox"/> Diaphragm  |
| <input type="checkbox"/> IUD, Type _____                  | <input type="checkbox"/> Suppository | <input type="checkbox"/> Sponge     |
| <input type="checkbox"/> Depo-Provera shots               | <input type="checkbox"/> Patch       | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Vaginal ring                     | <input type="checkbox"/> Other _____ |                                     |
| <input type="checkbox"/> Birth control pills - Name _____ |                                      |                                     |

**8. Pregnancy history:**  None

Please complete as completely as possible

	Number	Year(s)
<input type="checkbox"/> Miscarriages	_____	_____
<input type="checkbox"/> Abortions	_____	_____

Year	Sex	Type of delivery		Complications
		Vaginal	C-Section	

**9. Social History:**  None

<b>YES</b>	<b>NO</b>	Former	Current	Amount
<input type="checkbox"/>	<input type="checkbox"/> Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/> Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/> Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____

- Regular exercise  
  Safety concerns at home/Domestic violence

- Vaccination for HPV infection (Gardasil™ or Cervarix™)  
  Vaccination for Hepatitis

Have you completed an Advance Directive for Health Care (ADHC), Living Will, or POLST (Physician Orders for Life Sustaining Therapy)?

Reason for your visit today \_\_\_\_\_

Palm Beach Obstetrics & Gynecology LLC  
Review of systems

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please mark only the symptoms you are CURRENTLY experiencing:

**General**

- |                                     |                                      |                                       |                                  |
|-------------------------------------|--------------------------------------|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Body aches | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fever      | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain  |                                  |

**Eyes**

- |  |                                   |
|--|-----------------------------------|
| <input type="checkbox"/> Impaired vision | <input type="checkbox"/> Eye pain |
|--|-----------------------------------|

**HEENT**

- |                                    |   |                                      |                                      |
|------------------------------------|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Sore throat |
|------------------------------------|---|--------------------------------------|--------------------------------------|

**Breasts**

- |                                |                                     |                                   |   |
|--------------------------------|-------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Tenderness | <input type="checkbox"/> Swelling | <input type="checkbox"/> Nipple discharge |
|--------------------------------|-------------------------------------|-----------------------------------|---|

**Cardiovascular**

- |                                     |  |                                       |                                   |
|-------------------------------------|--|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Swelling |
|-------------------------------------|--|---------------------------------------|-----------------------------------|

**Respiratory**

- |  |                                |
|--|--------------------------------|
| <input type="checkbox"/> Short of breath | <input type="checkbox"/> Cough |
|--|--------------------------------|

**Gastrointestinal**

- |  |                                       |   |                                       |
|--|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Nausea          | <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Black stools | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Indigestion  |

**Genitourinary**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Urgency           | <input type="checkbox"/> Frequency        | <input type="checkbox"/> Pain urinating      | <input type="checkbox"/> Loss of urine       |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Painful periods  | <input type="checkbox"/> Heavy periods       | <input type="checkbox"/> Clots with periods  |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Vaginal blisters | <input type="checkbox"/> Nighttime urination | <input type="checkbox"/> Decreased sex drive |

**Skin**

- |                                 |                                  |   |
|---------------------------------|----------------------------------|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Changes to freckles or moles |
|---------------------------------|----------------------------------|---|

**Neurologic**

- |  |                                   |                                   |
|--|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Numbness |
|--|-----------------------------------|-----------------------------------|

**Musculoskeletal**

- |                                     |                                      |                                    |
|-------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Back pain |
|-------------------------------------|--------------------------------------|------------------------------------|

**Endocrine**

- |   |                               |  |
|---|-------------------------------|--|
| <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Acne | <input type="checkbox"/> Unusual hair growth |
|---|-------------------------------|--|

**Psychiatric**

- |                                  |                                     |  |  |
|----------------------------------|-------------------------------------|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Excessive anger |
|----------------------------------|-------------------------------------|--|--|

**Hematologic**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Swelling of lymph nodes |
|--|---|--|

**Immunologic**

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent illnesses |
|------------------------------------|---|