Seasons Women's Care – Patient Registration Form

Name: _____ Date of Birth: _____

Address: _____ City: _____ St: _____ Zip _____

Home Phone: _____ Cell: _____ Best Number: _____

Email: _____ Race or Ethnicity: _____

Marital Status: _____ SS# _____ Drivers Lic#: _____

Employer: _____ Work# _____ Occupation: _____

Spouse Name: _____ Phone# _____ Employer: _____

Emergency Contact: _____ Phone# _____ Relationship: _____

Primary Insurance Company Name: _____

Subscriber's Name & date of birth, if not patient: _____ DOB: _____

Primary Care Doctor's Name: _____ Phone # _____

Pharmacy Name: _____ Phone# _____

How did you hear about our practice? _____

I certify that the above information is correct, and further authorize the release of any medical information to any insurance carrier for any claim. I request payment of authorized benefits for physician services to the physicians or providers at Seasons Women's Care. I understand that I am responsible for any charges not paid by my insurance company. I also agree that should this account be referred to an agency or attorney for collection, I will be responsible for all collection fees, attorney fees and court costs. I am aware that payment is expected when services are rendered. I am aware that there is a $35 no show fee for appointments. If I need surgery, and the OR is booked, there is a $200 surgery cancellation fee if I cancel. I am also aware that should I need any disability paperwork filled out by my doctor that there is a $35 cash fee charge for this.

Signature of responsible party: _____ Date: _____

Seasons Women's Care

10115 Forest Hill Blvd., Suite 300
Wellington, FL 33414

Notice of Privacy Practices/HIPAA Acknowledgement

It is the policy of our practice that all physicians and staff preserve the integrity and confidentiality of Protected Health Information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI.

I acknowledge that I understand my right as a patient of this practice concerning my Protected Health Information (PHI). I am aware Seasons Women's Care reserves the right to change the privacy practices that are described in this Notice of Privacy Practices. I may obtain revised notice of Privacy Practices by contacting the office and requesting a revised copy be sent in the mail or asking for one at the time of my appointment

_____ _____
Printed Name of Patient or Personal Representative Date

_____ _____
Signature of Patient or Personal Representative Date

Blood Transfusion Information

In rare emergency situations, blood may need to be administered in the course of obstetrical or surgical treatment.

Is blood transfusion acceptable in an emergency? Yes_____ No_____*
If no, please explain:

*Please be aware that in the event of an emergency, our doctors will give a blood transfusion if deemed necessary in order to save your life and the life of your baby regardless of religious preferences.

_____ _____
Signature of Patient or Personal Representative Date

Seasons Women's Care

Personal Medical History

Name: **Date of Birth:** **Place of Birth:**

Reason for your visit: **Did someone refer you? If so, who?**

Please list all prescription medications you are currently taking:

Please list all vitamins and supplements you are taking:

ALLERGIES *(To medication or food)* ❑ No known Allergies

LAST PREVENTATIVE and SCREENING EXAMS

Pap Smear ❑no ❑yes When?	Where?	Result?	
Mammogram ❑no ❑yes When?	Where?	Result?	
Bone density/DXA ❑no ❑yes When?	Where?	Result?	
Colonoscopy ❑no ❑yes When?	Where?	Result?	

SURGICAL HISTORY *(list all surgeries)*

MENSTRUAL HISTORY ❑ N/A

First day of last period: Age at your first period: # of days you bleed:

Flow: ❑heavy ❑medium ❑light problems with period? ❑no ❑yes Explain:

What do you use for birth control (including Vasectomy):

MENOPAUSAL ❑ N/A

Age you stopped having periods: Problems or concerns? ❑no ❑yes:

Taking hormone therapy or other remedies? ❑no ❑yes – Please list:

SOCIAL HISTORY

Do You Smoke: ❑Yes ❑no How Much? **Alcohol intake**: ❑None ❑Occasional ❑Moderate ❑Heavy

Illegal Drugs: ❑Yes ❑No

Diet: ❑Regular ❑Vegetarian ❑Other Specify:_____ **Caffeine**: ❑None ❑Occasional ❑Moderate ❑Heavy

Exercise: ❑None ❑Occasional ❑Moderate ❑Heavy

Sexual orientation ❑Heterosexual ❑Homosexual ❑Bisexual **Are You:** ❑Married ❑Single ❑Separated ❑Divorced ❑widowed

Sexually Active? ❑Yes ❑No **In your life time how many Sexual partners:** ❑ >5 or ❑<5

History of Sexually Transmitted infection ❑Yes ❑No Type?_____

History of Domestic Violence ❑Yes ❑No **Sexual assault** ❑Yes ❑No

Highest level of education ❑8 ❑9 ❑10 ❑11 ❑12 ❑2yr college ❑4yr college ❑Post Graduate **Occupation**_____

Do you wear your seat belts routinely? ❑Yes ❑No **Do you accept Blood Transfusion?** ❑Yes ❑No

GYN HISTORY

History of: **Infertility** ❑Yes ❑No **Endometriosis** ❑Yes ❑No **Uterine Fibroids** ❑Yes ❑No **PCOS** ❑Yes ❑No

Ovarian problems ❑Yes ❑No **Abnormal Pap?** ❑Yes ❑No **History of LEEP or Cryo?** ❑Yes ❑No

Abnormal Mammogram? ❑Yes ❑No

List All Pregnancies (including miscarriages and/or abortions):

Year	Sex	Vaginal or C-Section	Full Term or Pre Term	Complications

 Name: _____

Circle all that apply

Cancer-Breast / BRCA Tested	GI-Vitamin Deficiency	Ortho-Chronic Back Pain
Cancer-Type:	GI-Colon Polyps/Hemorrhoids	Ortho-Fractures
Cardiac-Stent, Pace Maker, MVP*	GI-Crohn's/Ulcerative Colitis	Ortho-Other
Cardiac-Heart Arrhythmia	GI-Gallbladder Disease	Psych-Eating Disorder/PMS/PMDD
Cardiac-Heart Disease *	GI- Other	Psych-Anxiety/ Depression/ADD/Bipolar
Cardiac-High Blood Pressure	Hematology-Blood Clotting Disorder/Factor V Leiden	Psych-Other
Cardiac-High Cholesterol	Hematology- Bleeding Disorder/Anemia	Pulmonary- Asthma
Cardiac Other:	Hematology-Blood Transfusion	Pulmonary-Seasonal Allergies/Allergic Rhinitis
Dermatology- Acne/Eczema/Psoriasis	Hematology-DVT/Pulmonary Embolism	Pulmonary-Sleep Apnea
Dermatology- Other	Hematology- Other	Pulmonary- Other
ENT- Hearing Loss	ID-Tuberculosis/Positive PPD	Rheumatology-Autoimmune Disease
ENT-Other	ID-Chicken Pox/Shingles/Rheumatic Fever	Rheumatology-Fibromyalgia/Chronic Pain
Endocrinology-Thyroid Problems Explain:	ID-HIV	Rheumatology- Arthritis
Endocrinology-Diabetes/History of Gestational Diabetes	ID-MRSA	Rheumatology-Restless Leg Syndrome
Endocrinology-Elevated Prolactin	ID-Other	Rheumatology- Other
Endocrinology-Osteopenia , Osteoporosis	Neurology-Headaches/Migraines	Urology-Hematuria (Blood in Urine)
Endocrinology-Other	Neurology- Neuropathy	Urology-Interstitial Cystitis
Eyes-Cataracts ,Glaucoma	Neurology-Seizures/Epilepsy/Stroke/TIA	Urology-Kidney Disease
Eyes- Vision Loss/Macular Degeneration	Neurology- Other	Urology-Kidney Infection
Eyes- Other	Ortho-Degenerative Joint Disease	Urology-Frequent Urinary Tract Infections
GI-Liver Disease/Hepatitis	Orthopedic- Artificial Joint*	Urology- Other
GI- Irritable Bowel Syndrome	Ortho-Chronic Back Pain	
GI-Reflux/Stomach Ulcers	Ortho-Fractures	

Anything you would like to add?

_____

_____

_____

Family History of Illness (Cancer, Diabetes, etc):

Mother: Alive/Well Deceased and/or illness: _____

Father: Alive/Well Deceased and/or illness: _____

Brother: Alive/Well Deceased and/or illness: _____

Sister: Alive/Well Deceased and/or illness: _____

Patient Signature _____ Date _____

Seasons
WOMEN'S CARE

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome and Lynch syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colorectal cancer before age 50			
Y	N	Two or more Lynch syndrome cancers* in the same person or on the same side of the family			
		(*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)			
		BREAST AND OVARIAN CANCER	**SELF**	**FAMILY MEMBER**	**AGE AT DIAGNOSIS**
Y	N	Breast cancer at age 50 or younger			
Y	N	Ovarian cancer			
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y	N	Male breast cancer			
Y	N	Triple negative breast cancer† (ER-, PR-, HER2- pathology)			
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			
Y	N	Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain:			

_____ _____

Patient's Signature Date

FOR OFFICE USE ONLY

☐ Candidate for further risk assessment and/or genetic testing: ☐ Lynch ☐ HBOC

☐ Information given to patient to review

☐ Follow-up appointment scheduled Date: _____

☐ Patient offered genetic testing:
☐ Accepted
☐ Declined

_____ _____

Healthcare Professional's Signature Date

† For a better understanding of triple negative breast cancer, please ask your healthcare provider.
Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.myriadtests.com/patient_guidelines

MYRIAD