Oak Medical Clinic

Gynecology and Obstetrics

Patient Registration Information

Personal Information Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

RACE: WHITE___ BLACK: ___ ASIAN: ____ OTHER: _____ ETHNICITY: HISP_____ NON-HISP _____ Refuse to report: ____

Social Security No: _____ Gender: ☐ Male ☐ Female

Name: _____ DOB: _____ Age: _____

Address: _____ Apt./Lot No. _____ zip code _____

Phones: (OK to leave messages? Home: _____ Cell: _____ Work: _____

Primary Doctor _____ Phone _____ Do not have a Primary Doctor __

Pharmacy (Name and Dirreccion) _____Phone_____Fax_____

EMAIL (For Portal Access): _____ Primary Language: _____

Insurance Information

Primary Insurance Company_____ Is This You Only Insurance Policy? Yes ☐ No ☐

Policy Holder's Name: _____ DOB: _____

SS No.: _____ Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Policy ID: _____Group Name/No.: _____

Secondary Insurance Company _____

Policy Holder's Name: _____ DOB: _____

SS No.: _____ Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Policy ID: _____Group Name/No.: _____

Responsible Party Information **Legal Guardian** ☐

Name: _____ DOB: _____ Social Security No: _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other _____

Address: _____ Apt./Lot No. _____ zip code _____

Phones: (OK to leave messages? Home: _____ Cell: _____ Work: _____

Emergency Contact Information

Name: _____ Relationship_____Phone No:_____

Is this emergency contact able to receive personal information for HIPPA purposes? ☐ **Yes** ☐ **No**

How did you hear about our office? ☐ **Phone Book** ☐ **Hospital Name** _____

Friend or Family Member _____ **May we thank him/her?** ☐ **Yes** ☐ **No**

_____ _____

Signature Date

_____ _____

Legal Guardian Name/ Signature Date

Oak Medical Clinic

Gynecology and Obstetrics

PATIENT HISTORY (FORM 1)

Patient Name: _____ Date of Birth: _____Today's Date: ____/____/____

REASON FOR CONSULTATION: ( ) ANNUAL ( ) ABN. BLEEDING ( ) DISCHARGE ( ) BREAST LUMP ( ) INFERTILITY
( ) PELVIC PAIN ( ) PREGNANCY ( ) OTHER _____

Check Symptoms you currently have or have had in the past year

GENERAL
( ) Chills
( ) Depression
( ) Dizziness
( ) Fainting
( ) Fever
( ) Headache
( ) Loss of sleep
( ) Loss of weight
( ) Nervousness
( ) Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in
( ) Arms ( ) Hips
( ) Back ( ) Legs
( ) Feet ( ) Neck
( ) Hands ( ) Shoulders

GENITO-URINARY
( ) Blood in urine
( ) Frequent urination
( ) Lack of bladder control
( ) Painful urination

GASTROINTESTINAL
( ) Appetite poor
( ) Bloating
( ) Bowel changes
( ) Constipation
( ) Diarrhea
( ) Excessive hunger
( ) Excessive thirst
( ) Gas
( ) Hemorrhoids
( ) Indigestion
( ) Nausea
( ) Rectal bleeding
( ) Stomach pain
( ) Vomiting
( ) Vomiting blood

CARDIOVASCULAR
( ) High blood pressure
( ) Irregular heart beat
( ) Rapid heart beat
( ) Swelling of ankles

EYE, EAR, NOSE, THROAT
( ) Bleeding gums
( ) Blurred vision
( ) Earache
( ) Hay fever
( ) Nosebleeds
( ) Persistent cough
( ) Sinus problems

SKIN
( ) Bruise easily
( ) Hives
( ) Itching
( ) Change in moods
( ) Rash
( ) Scars
( ) Sore that wouldn't heal

WOMEN ONLY
Have you had
a mammogram? _____
Are you pregnant? _____
Number of children? _____

WOMEN ONLY
( ) Abnormal pap smear
( ) Bleeding between periods
( ) Breast lump
( ) Extreme mensual pain
( ) Hot flashes
( ) Nipple discharge
( ) Painful intercourse
( ) Vaginal discharge
( ) Other

Date of last menstrual
Period _____

Date of last
Pap Smear: _____

List Medication you are currently taking

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List Allergies

_____
_____
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_____

_____ _____
Signature Date

_____ _____
Legal Guardian Name/Signature Date

Oak Medical Clinic

Gynecology and Obstetrics

PATIENT HISTORY (FORM 2)

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** ____/____/____

GYNECOLOGICAL HISTORY

MENSTRUAL CYCLE: Age at first menstruation: _____ First day of last menstruation: **(LMP)** ____/____/____
Frequency: Every ___ days (Normal 21–40 days). Lasting for ____ days (Normal: 2-7 days)
PAIN: ( ) None ( ) Mild ( ) Mod. to severe
AMOUNT: ( ) Normal ( ) Moderate ( ) Heavy (___ pads/day)

CONTRACEPTION: ( ) None ( ) Pills ( ) IUD ( ) Condoms ( ) Spermicides
( ) Depo-Provera ( ) Menopause ( ) Tubal ( ) Partner vasectomy
( ) Hysterectomy ( ) Rhythm ( ) Abstinence ( ) Other:__

SEXUAL HISTORY: ( ) Non-active ( ) Satisfactory ( ) Painful ( ) Post-coital bleeding ( ) Wish to discuss
Age at first coitus: ( ) Number of sexual partners: This past year: ( ) Past 5 years ( )

PAP SMEAR: Date: ____/____/____ ( ) No ( ) Normal ( ) ABN

MAMMOGRAM: Date: ____/____/____ ( ) No ( ) Normal ( ) ABN

PAST & FAMILY HISTORY **(CHECK √) IF YOU (YOURSELF) OR A BLOOD RELATIVE (FAMILY) HAS ANY OF THE FOLLOWING CONDITIONS, AND SPECIFY WHICH MEMBER)**

	SELF/FAM		SPECIFY			SELF/FAM		SPECIFY
High cholesterol					Breast problems			
Heart disease Rheumatic fever					Cancer Type:			
High blood pressure					Neurological disease			
Lung disease, Asthma or Bronchitis					Psychiatric disorder or Anorexia			
Tuberculosis, Emphysema					Anxiety/Depression			
Kidney or Bladder problems					Infertility			
Diabetes					Genital herpes or Genital warts			
Thyroid disease					Chlamydia, Syphilis or Gonorrhea			
Liver disease, Hepatitis (Type_____)					HIV test–Positive or AIDS			
Stomach, Bowell or Gallbladder problems					( ) Alcohol abuse ( ) Street drugs			
Blood transfusions					Smoking			
Anemia or Blood disorder					DVT			

Hospitalization/Surgeries (Specifies) **( ) None** **( ) Yes, as fallows**

Month/Year			Month/Year		
/			/		
/			/		
/			/		
/			/		

_____ _____
Signature Date

_____ _____
Legal Guardian Name/Signature Date

Oak Medical Clinic

Gynecology and Obstetrics

PATIENT HISTORY (FORM 3)

Patient Name: _____ Date of Birth: _____Today's Date: ____/____/____

Obstetric History

PREGNANCIES **( ) NONE ( ) YES, as follows:**

Total Pregnancies	Full Term	Prematures	Miscarriages	Abortions	Ectopic	Multiple Births	Living

Date Month/ Year	Gest. Age (Weeks)	Birth Weight No. oz.	Sex M/F	Type of delivery Vag. Or C/S	Place of Delivery	Complications / Comments
/						
/						
/						
/						
/						
/						

Genetic History

GENETIC HISTORY (Includes patient, baby's father, or anyone in either family) ( ) **N/A**

	Yes	No			Yes	No
Patient's age over 35				Huntington's Chorea		
Thalassemia: MCV < 80				Mental retardation/Autism (If yes, was person tested for fragile x?)		
Neural tube defect (Spina bifida, meningomyelocele or anencephaly)				Cystic fibrosis		
Congenital heart defect				Recurrent pregnancy loss, or previous stillbirth		
Down's Syndrome				Other inherited, generic or chromosomal disorder		
Tay-sachs				You or baby's father had a baby with birth defects not listed above		
Sickle cell disease or trait				Medications/street drugs/alcohol since last menstruation		
Hemophilia				Other:		
Muscular dystrophy						

ADDITIONAL COMMENTS: _____

_____

_____ _____

Signature Date

_____ _____

Legal Guardian Name/ Signature Date

Oak Medical Clinic

Gynecology and Obstetrics

805 E Oak Street, Suite 1, Kissimmee, FL 34744

407-933-0021 / Fax 407-933-1490

MEDICATION HISTORY CONSENT FORM

By signing this consent form, I give permission to Oak Medical Clinic to access my pharmacy benefits data electronically through RX HUB. This consent will enable Oak Medical Clinic to;

1. Determine the pharmacy benefits and drug co-pay for patient's health plan.
2. Check whether a prescribed medication is covered (under formulary) under patient's plan.
3. Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
4. Determine if patient's health plan allows electronic prescribing to mail orders pharmacies.
5. Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask you permission to obtain formulary information, and information regarding other prescriptions prescribed by other providers using RX HUB.

_____ _____

Signature Date

_____ _____

Legal Guardian Name/ Signature Date

Oak Medical Clinic

Gynecology and Obstetrics

Release of Information & Assignment of Benefits

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to **ALEX ROJAS, M.D. LLC**. I authorize any holder of medical information about me to release to my insurance and their agents any information needed to determine these benefits or the benefits payable for related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. **Dr. Alex Rojas, M.D.** accepts the charge determination of the insurance carrier as the full charge, and I am responsible for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the insurance carrier. If for any reason the insurance company does not honor their contract and payment is not forthcoming or if the insurance company does not pay the entire claim, then I will be responsible for the full or remaining balance.

Medicare, (under Section 1862 (a)(1) of the Medicare law), and some health insurance plans will only pay for services that deems to be “reasonable and necessary”. If Medicare determines that a particular service is not reasonable or necessary or my insurance company determines that service was not authorized or not covered under my plan, Medicare or my insurance company will deny payment. Payment then will be my responsibility.

I understand that I am financially responsible for *any balance not covered by my insurance carrier, and after all applicable adjustment per insurance contract has been applied***.**

_____ _____

Signature of Patient Date

_____ _____

Legal Guardian Name/Signature Date

Oak Medical Clinic

Gynecology and Obstetrics

PATIENT CONSENT FORM

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures, tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or his/her assigned designees

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

I understand that Alex Rojas, M.D. LLC may include this consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Alex Rojas, M.D. LLC will use and disclose my information for the purposes of treatment, payment and healthcare operations as described in the Notice of Privacy Practices.

A photocopy or scan documents of this consent shall be considered as valid as the original.

MEDICAID/MEDICARE PATIENTS

I authorize the release of medical information about me to the Social Security Administration or its intermediaries for my claims. I assign the benefits payable for services to Alex Rojas, M.D. LLC.

I acknowledge that I have been given the Notice of Privacy Practices by Dr. Alex Rojas, M.D. LLC. I understand that if I have questions or complaints that I should contact the Privacy Official.
Patient initial: _____.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

_____ _____
Signature Date

_____ _____
Legal Guardian Name/ Signature Date

Oak Medical Clinic

Gynecology and Obstetrics

805 E Oak Street, Suite 1, Kissimmee, FL 34744

407-933-0021 / Fax 407-933-1490

Living Will

(FLORIDA DECLARATION)

On this _____day of_____, 20_____ I, _____

Last name *First Name* *Middle Name*

Of my own free will, make known my desire that my dying not to be artificial prolonged under any of the circumstances set out below, and I do hereby declare that.

Should I develop a terminal condition, and if my attending physician determines that there can be no reasonable expectation of recovery from such a condition, and that my death is imminent, I hereby direct that life prolonging procedures be withheld or withdrawn when such procedures serve only to artificially prolong the process of my dying under such circumstances. It is my desire that I be permitted to die naturally , with only the administration of such medication or the performance of any such medical procedure judged necessary to provide me with comfort and to provide pain relief. Relating to the administration of nutrition and hydration (food and fluid). I do _____, I do not _____(check one)desire that such be withheld or withdrawn when such procedures serve to only prolong in an artificial way the process of my dying. It is my intent that , should I be unable to give directions regarding the use of life-prolonging procedures, that this represent the declaration of my intent that will be honored by my physicians, as well as by my family, as a valid representation of my legal right to refuse medical and/or surgical treatment and to accept the consequences as such.

I fully understand the importance and consequences of this declaration. I am competent to make such declaration, and it is my desire to do so. I make this declaration without coercion and of my own free will.

(If I am diagnosed as pregnant and that diagnosis is known to my physician, this declaration shall not be in effect in the course of my pregnancy.)

I do _____, I do Not _____ (check one) desire to donate my organs.

SIGNATURE: _____

DECLARATION OF WITNESS:

The above is known to me, and it is my judgment that he/she is of sound mind and is making the above declaration of his/her free will.

WITNESS: _____RELATIONSHIP: _____

I DO NOT WANT A LIVING WILL: _____DATE:_____

NOTE: *One witness should not be a spouse nor a blood relative of the declaration in a compliance with Florida State 765 amended effective 10/01/90*

_____ _____

Signature Date

_____ _____

Legal Guardian Name/ Signature Date

Oak Medical Clinic
Office Policies
Please read thoroughly

Thank you for choosing us as your Obstetrics and Gynecology care provider. We are committed to providing you with quality and affordable health care. Below are our office financial policies created to better serve you. **Please read it and ask us any questions you may have.**

- **Phones.** If you have an emergency at any time, please call 911. Telephones will be answered by the office Monday through Thursday from 8:30 a.m. to 5:30 p.m. and Friday till 12:00pm. The office has answering service coverage for after hours for medical necessity, the provider is informed and will then attend the medical necessity in a timely manner. **Please note that prescription refills and referrals are not considered emergencies and will only be attended during office hours, please give 24 hours for these requests.**
- **Test Results.** Should you have any laboratory work or other diagnostic testing done through our practice, your results will be notified if necessary as soon as they are available (please refrain your inquiries for at least 2 weeks) as they must first be reviewed by the physician. A fee per page will be charged if you will like to have copies. Note, that it will be free of charge when sent by fax to the primary physician office.
- **Records Release.** It could take our office up to 7 business days after receiving a written authorization to release medical records to another physician, these will be free of charge. A fee per page will be charged if you will like to have copies.
- **Services that may become patient responsibility. Please be aware that some services billed through your insurance may become your responsibility, such as copayment, co-insurance, deductible and none covered services.**
- **The Completion of forms and letters.** Our office charges a fee for these services.
- **Losing Forms. (Labs, Ultrasounds, scripts, referrals, etc. that the doctor gave you)** Fees per page will be charged.
- **Missed, Cancel or Reschedule Hospital Procedures.** If you miss an appointment or cancel less than 48 hours' notice. Oak Medial Clinic, reserves the right to bill you for each **No Show** and **Late Cancellation**.
- **Missed, Cancel or Reschedule Office Hysteroscopy.** If you miss an appointment or cancel less than 48 hours' notice. Oak Medial Clinic, reserves the right to bill you for each **No Show** and **Late Cancellation**.
- **Missed, Cancel or Reschedule Office Procedures (Colposcopy, Ultrasound, Biopsy and IUD).** If you miss an appointment or cancel less than 24 hours' notice. Oak Medial Clinic, reserves the right to bill you for each **No Show** and **Late Cancellation**.
- **Missed, Cancel or Reschedule Office Appointments.** If you miss an appointment or cancel less than 24 hours' notice. Oak Medial Clinic, reserves the right to bill you for each **No Show** and **Late Cancellation**.

Oak Medial Clinic, reserves the right to bill you for each **No Show** and **Late Cancellation**. This fee will be your responsibility and will not be billed to your insurance company. In addition to the fee with each missed appointment, we will notify you of our policy if you have missed three (3) or more appointments without no notification or validation. Additionally, we reserve the right to terminate our relationship with you (our patient) after **five (5)** or more occurrences. Good care and positive doctor-patient relationship are dependent upon consistent consultations and treatment. This cannot be accomplished with frequent missed appointments.

I CERTIFIED THAT I HAVE READ AND FULLY UNDERSTOOD THE ABOVE NOTIFICATION.

Financial policies will be in the main waiting room area. Keep in mind that fees may change every year.

_____ _____

Name/Signature Date

_____ _____

Legal Guardian Name/ Signature Date