OB/GYN CONCIERGE HEALTH LLC.

3893 Military Trail, Suite 1
Jupiter, FL 33458
561.744.8319

LAST NAME _____ FIRST _____ MIDDLE _____ PREFER TO BE CALLED _____

BIRTHDATE _____ SOCIAL SECURITY # _____ DRIVERS LICENSE # _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE NUMBER _____ WORK PHONE NUMBER _____ CELL PHONE NUMBER _____ MARITAL STATUS _____

REFERRING PHYSICIAN _____ REFERRED BY _____ PRIMARY LANGUAGE _____

SPOUSE OR EMERGENCY CONTACT NAME _____ RELATION _____ PHONE NUMBER _____

PHARMACY NAME _____ PHARMACY PHONE NUMBER _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ EMPLOYER PHONE NUMBER _____

FINANCIAL ARRANGEMENTS:

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT. For your convenience we accept payment by cash, check, Visa or Mastercard.

I acknowledge that insurance panels are closed for OB/GYN Concierge Health LLC. or that my insurance company is not contracted with OB/GYN Concierge Health LLC. and I have chosen to become a Concierge patient on a private pay basis. This means that I will be directly responsilbe for all charges.

OB/GYN Concierge Health LLC. gladly assist you in receiving the full benefits of your insurance policy coverage. However, we can make no guarantee of any estimated coverage because the insurance policy is an agreement between you and the insurance company. We require all patients to be directly responsible for all charges.

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

OB/GYN CONCIERGE HEALTH LLC.
MEDICAL HISTORY

LAST NAME FIRST MIDDLE AGE BIRTHDATE

DRUG ALLERGIES: _____

MEDICATIONS LIST: SURGERIES LIST:

CHECK IF YOU HAVE A PERSONAL HISTORY OF:

- ☐ ABNORMAL MAMMOGRAM
- ☐ ABUSE - SEXUAL/PHYSICAL
- ☐ ACNE
- ☐ ALCOHOLISM
- ☐ ALLERGIES
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ANEMIA
- ☐ DVT or PULMONARY EMBOLISM
- ☐ BLOOD TRANSFUSIONS
- ☐ BREAST DISEASE
- ☐ CANCER_____
- ☐ HIGH CHOLESTEROL
- ☐ COLITIS
- ☐ DEPRESSION
- ☐ DIABETES/LOW BLOOD SUGAR
- ☐ DIVERTICULOSIS
- ☐ DRUG DEPENDENCY
- ☐ EMOTIONAL PROBLEMS
- ☐ EPILEPSY/SEIZURES
- ☐ EYE PROBLEMS
- ☐ GLAUCOMA
- ☐ GALLBLADDER PROBLEMS
- ☐ HEADACHES
- ☐ HEART PROBLEMS
- ☐ GENETIC DISORDER
- ☐ HEPATITIS
- ☐ HERNIA
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV TESTING
- ☐ INTESTINAL PROBLEMS
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MITRAL VALVE PROLAPSE
- ☐ NEUROLOGIC PROBLEMS
- ☐ OSTEOPOROSIS
- ☐ LUNG DISEASE
- ☐ RHEUMATIC/SCARLET FEVER
- ☐ AUTISM
- ☐ STROKE
- ☐ SICKLE CELL ANEMIA
- ☐ ADHD or ADD
- ☐ THYROID DISEASE
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ DISABILITY
- ☐ URINARY INCONTINENCE
- ☐ ANXIETY DISORDER
- ☐ OTHER:

OBSTETRICAL HSTORY:

TOTAL PREG	FULL TERM	PREMATURE	MISCARRIAGE	ABORTION	ECTOPICS	MULTIPLE BIRTH	LIVING

PAST PREGNANCIES:

DATE	SEX	WEIGHT	VAGINAL OR C/S	COMPLICATIONS

GYNECOLOGIC HISTORY:

ANY INFECTIONS: HERPES CHLAMYDIA GONORRHEA SYPHILIS HPV / WARTS OTHER:

ANY ABNORMAL PAPS? _____ TREATMENT: _____ DATE OF LAST PAP: _____

DATE LAST MAMMOGRAM: _____ BONE DENSITY: _____ COLONOSCOPY: _____

PERIODS BEGAN AGE: _____ MENOPAUSE: _____ HORMONE THERAPY: _____

SEXUALLY ACTIVE: YES / NO TYPE OF CONTRACEPTION USED, IF ANY: _____

MENSES OCCUR EVERY _____ DAYS, LAST ABOUT _____ DAYS, WITH HEAVY / MODERATE / LIGHT FLOW

LIST ANY GYNECOLOGIC / MENSTRUAL / SEXUAL PROBLEMS: _____

LIST MEDICAL ILLNESSES IN FAMILY MEMBERS:

PARENTS: GRANDPARENTS:

SIBLINGS: CHILDREN:

PATIENT SOCIAL HISTORY:

YOUR HIGHEST LEVEL OF EDUCATION: _____

YOUR OCCUPATION: _____ RETIRED

SINGLE / MARRIED / DIVORCED / WIDOWED / IN A RELATIONSHIP

CIGARETTE SMOKER: FORMER / CURRENT / NEVER

ALCOHOL USE: YES / NO DAILY / WEEKLY / OCCASIONALLY

DRUG USE: FORMER / CURRENT / NEVER

YOUR PRIMARY PHYSICIAN'S NAME:

OB/GYN CONCIERGE HEALTH LLC.

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"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 MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

_____ _____

Patient/Responsible Party Date

OB/GYN CONCIERGE HEALTH LLC.
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CONFIDENTIAL COMMUNICATIONS

By signing below you give our practice permission to communicate test results by leaving a message on your voice mail, answering machine, cell phone, home phone.

SIGNATURE _____ DATE _____ WITNESS _____

OBGYN CONCIERGE HEALTH LLC

CONSENT FOR PELVIC EXAMINATION

A pelvic Examination is an examination of the vagina, cervix, uterus Fallopian tubes, ovaries rectum, or external pelvic tissue or organs. this procedure is used to diagnose and / or treat conditions that involves the pelvis. It may be performed using any combination of modalities, which may include the healthcare provider's gloved hand or instrumentation, for purpose of this consent, vaginal Sonography is included.

By signing this consent, I_____ Authorize and direct

(Print Patient's Name)

Lisa R Hearing MD , my treating physician as a healthcare provider to perform a pelvic examination may be needed while receiving medical care. hereby agree and acknowledge that this written consent applies

to any and all pelvic examinations conducted today, or in the future, by a health care provider, or student receiving medical training as a health care provider employed by Lisa R Hearing MD.

Unless I revoke this consent in writing by hand delivering a copy to Dr. Lisa R Hearing, by my signature below I acknowledge that I have read or have read to me and understand the content of this form

_____Patient/Legal

Representative Signature Print Name and Date

_____Witness

Signature Print Name and Date

OBGYN Concierge Health

"No Show" & "Late Cancellation" Policy

Description

"No Show " shall mean any patient who fails to arrive for a scheduled appointment.

"Same Day Cancellation," or "Late Cancellation," shall mean any patient who cancels an appointment less than 24 hrs before their scheduled appointment.

Policy

OBGYN Concierge Health's goal is to provide excellent care to each patient in a timely manner.

If it is necessary to cancel an appointment, patients are required to notify the office at least 24 hours before their appointment time.

Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

Procedure

I. A patient is notified of the appointment "No Show" & "Late Cancellation" Policy at the time of scheduling. This policy can and will be provided in writing to patients at their request.

II. Established / New Patients: Appointments must be canceled at least 24 hours prior to the scheduled appointment time

III. In the event of "No-Show" & "Late Cancellation" less than 24 hours prior to the scheduled appointment time, **a $55 fee will be charged to patient.**

Patient Legal Representative Signature

Print Name and Date