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Julie M. King, DO, FACOOG

Dalibor I. Hradek, MD, FACOG

Tracy L. Grathwohl, ARNP

PATIENT INFORMATION FORM

Last Name: ________________________ First Name: ____________ MI: _________ Status: SIN MAR WID DIV

Address: ____

Home Phone : ___________________ Cell Phone:_____________________ Work Phone: __________________________

DOB: ____________________ Age: ___________ Email Address: ____

How Did You Find Out About Us? ☐ Friend/Family ☐ Co-Worker ☐ Internet Search ☐ Event ☐ Facebook

☐ Advertising ☐ Insurance Website ☐ Doctor ☐ ZocDoc ☐ Other

____

Your Preferred Language: English/Spanish/Other ___________________________________

Your Ethnicity: Hispanic or Latino/Not Hispanic or Latino/Unknown/Decline

Your Race: American Indian or Alaska Native/Black or African American/Native Hawaiian or Other Pacific Islander/ White/Other Race/Prefer Not To Say

Social Security #: ______________________________ Your Primary Care Physician: ______________________________

Emergency Contact Name: ____ DOB: ________________________

Relationship to Patient: ____

Primary Insurance: ____

Primary Insured Name: _______________________________ Primary Insured DOB: _____________________

Relationship to Patient: _____________________________ ID #: ____________________________________

Secondary Insurance: ____

CONSENT TO TREATMENT

I request those physicians and other healthcare professionals who care for me to perform or order routine laboratory/diagnostic procedures and therapeutic treatments, which in the judgment of my physician, allows them to document the course of my injury or illness and to provide appropriate medical care. I also understand that it is the policy of Lakewood Ranch OBGYN to perform routine urine testing if needed and urine pregnancy testing on every patient of child-bearing age unless they have had a complete hysterectomy. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the treatments or examinations.

Signature: ____ Date: ____________________________________

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME:________________________________ DOB: ____________________ SSN: ______________________

I hereby authorize Lakewood Ranch OBGYN to use and disclose a copy of my health and medical information as described below.

☐ SEND MY RECORDS TO: ☐ OBTAIN MY RECORDS FROM:

Doctor's Name: _____________________________________ Doctor's **FAX**: _____________________________

Doctor's address:____

Purpose: ☐ Continued Medical Care ☐ New Patient ☐ Transfer Care ☐ Personal Use

Type of Information: ☐ PAPS, MAMMOS, BONE SCANS + U/S ONLY ☐OTHER _______________________________

I understand that I may revoke this consent at any time by submitting such a request in writing, except where information has already been released. This authorization is valid for sixty (60) days from the date it is signed.

Patient Signature: ____ Date: __________________

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion or mental health treatment. Separate consent must be given before this information can be released.

☐ I DO consent to have this information disclosed ☐ I DO NOT consent to this information being disclosed

Patient Signature: ____ Date: __________________

This medical record may contain information concerning HIV testing and/or AIDS diagnosis. Separate consent must be given before this information can be released.

☐ I DO consent to have this information disclosed ☐ I DO NOT consent to this information being disclosed

Patient Signature: ____ Date: __________________

LAKEWOOD RANCH OBGYN reserves the right to charge a fee for copying medical records. There will be a fee of $1 per page for the first 15 pages then $0.25 per page thereafter. Please allow a minimum of 48 hours' notice for copying of medical records.

Patient Signature: ____ Date: __________________

8340 Lakewood Ranch Blvd., Suite 140, Bradenton, FL 34202. Tel: (941) 907 9298 Fax: (941) 907 9148

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PATIENT MEDICAL HISTORY

Patient Name: ____ **Date of Birth**: _______________

Married/Single/Divorced/Widowed (please circle one) **Occupation:** _____________________________________

Primary Care Doctor: ____________________________________ **Referred By:** _____________________________________

Gynecological

Last Monthly Period: _________________ Sexually Active: ____________________ Partners are: Men Women Both

Current method of contraception:____________________________ Do you perform regular self-breast examinations? : Yes No

Pregnancy Detail – Please List All Pregnancy Details (If Any) REGARDLESS OF YOUR AGE

Pregnancies: ___________________ Miscarriages: _____________________ Abortions: ___________________________

Child	Birth Date	Birth Weight	Baby's Sex	Weeks of Gestation	Type of Delivery	Notes
1						
2						
3						
4						

Complications During Pregnancy: Diabetes / Hypertension / High Blood Pressure / Pre-eclampsia / Toxemia / Depression / Other:____

Check all that apply. Include date of last testing.

☐ Pap smear_____________ ☐ DEXA Bone Density Scan_____________ ☐ Mammo____________ ☐ Colonoscopy____________

Have any of the above been abnormal? YES NO

Which of the above were abnormal?____

Allergies + Reactions: ____

Pharmacy: ____

SOCIAL HISTORY:

	Current Use	Prior Use	Amount Daily	# Years
Tobacco				
Alcohol				
Drugs				

Current Meds:

____
____
____
____
____
____

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Patient Name: ____ **Date of Birth**: ________/_________/________

Surgical History

	Surgery	Year	Comments
1			
2			
3			
4			

Medical History (Please check applicable boxes below.)

		SELF	FAMILY MEMBER (Who?)			SELF	FAMILY MEMBER (Who?)
1	Adopted			27	HIV/AIDS		
2	Allergies			28	Hypertension		
3	Alcohol or drug problems			29	Infectious disease/immunizations		
4	Alzheimer's disease			30	Infertility		
5	Anxiety			31	Inheritable diseases		
6	Asthma			32	Lupus		
7	Autoimmune/lymphatic/hematologic			33	Menopausal		
8	Bleeding/bruising			34	Mental illness		
9	Birth Defects			35	Musculoskeletal		
10	Breast			36	Neurological		
11	Cancer (use NOTE space below)			37	Osteoarthritis		
12	Cardiovascular			38	Osteoporosis		
13	Depression			39	Polycystic Ovaries		
14	Diabetes			40	Psychological		
15	Drug allergies			41	Respiratory		
16	Early menopause			42	Rheumatoid arthritis		
17	Endocrine			43	Sickle cell disease		
18	Endometriosis			44	Skin diseases		
19	Gastrointestinal			45	Smoking		
20	Genetic history and screening			46	Stroke		
21	Gynecological			47	Tay-Sachs disease		
22	Heart attack/disease			48	Thalassemia		
23	Hepatitis			49	Tuberculosis		
24	High cholesterol			50	Urinary		
25	Hip fracture			51	Venous thrombosis		
26	History of problems with anesthesia						

Notes:____
____
____

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Patient Consent to Receive Mail and/or Telephone messages

Patient Name: ____ DOB:____________________

Telephone call/voice mail permission for work and/or home:

Appointment confirmation: Yes____ No____
Billing information: Yes____ No____
Medical information/results: Yes____ No____

Mailing permission:

Send yearly appointment card reminder: Yes____ No____
Test results: Yes____ No____

Consent for my information released to:	**Appointment**	**Medical**	**Billing**
Name: _________________________________	O	O	O

Phone: __________________________ Relationship___________________________

Name: _________________________________	O	O	O

Phone: __________________________ Relationship___________________________

Continued On Back →

HIPAA ACKNOWLEDGMENT

1) I understand that I may revoke this authorization at any time by notifying LWR OBGYN in writing.
2) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits.
3) I may inspect or copy any information used or disclosed under this agreement.
4) I understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.
5) I hereby acknowledge receipt of the Notice of Privacy Practices.

Patient Signature: ___________________________________ Date: ________________________

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

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Office Policies and Procedures

Appointment policy-

New patient appointments need to arrive 30 mins prior to their scheduled appointment. Established patients need to arrive 15 mins prior to their scheduled appointment. You will need to bring photo id and insurance card to each appointment. Patients that arrive 10 mins past their appointment time will be worked in between patients if possible. Otherwise, if time does not permit the patient will need to be rescheduled.

Cancellation policy-

We request the 24 hours' notice if you are unable to keep your scheduled appointment. We do call 48 hours in advance to confirm all appointments. Any "no show" appointments will be subjected to a $50 "no show" fee. This is directly billed to you as your insurance is not responsible.

Payment policy-

All payments are due at the time of service. This includes Co-pays, Deductibles and Co-Insurance. We accept cash, check, Visa, Master Card, American Express and Discover. If you are unable to meet your financial obligations you will need to speak with the Office Manager or reschedule your appointment.

Financial policy-

Lakewood Ranch OB/GYN, LLC under the VitalMD network participates with most insurance carriers. It is the patient's responsibility to verify that our providers are in your insurance plan's network. It is also the patient's responsibility to know their insurance plan coverage and deductibles. We will file your claims as a courtesy to all insurance plans that we participate with. Any remaining balance that is patient stated is due either at your next visit or statement in the mail (Whichever comes 1st). Any balance not paid within 120 days is subject to collections. Any and all fees associated with sending an account to collections is the patient's responsibility.

Phone calls-

All calls are answered during office hours only. Messages left during business hours will be returned by the end of the day. Messages left after hours will be returned the next business day. If you are having an emergency please call 911 or go directly to the ER.

Prescription refills-

All prescriptions should be called into your pharmacy. They will send us a request that will be reviewed by the physician. This can take up to 72 hours to complete and send back to your pharmacy. Prescriptions will be refilled if there has been an appointment within the last year. Otherwise, only a 1 month supply with be given and an appointment must be made prior to any additional refills will be given.

Hospital visits-

Our physicians only maintain privileges at Lakewood Ranch Medical Center. If admitted to LWRMC and in need of OB or GYN services our on-call physician will see you.

Medical records policy-

All requests for medical records require a Medical Records Release form to be completed. Copies of records for personal use are subject to a fee of $1 for the first 15 pages and 25 cents for each additional page. All records requests will be completed within 7 days of receipt.