NAME: ______________________ TODAY'S DATE: ____________

DATE OF BIRTH: ____________ EMAIL: ______________________

HOME ADDRESS: ______________________________________

PHONE NUMBER(S): HOME:(_____) ______-______ MOBILE:(_____) ______-______
WORK:(_____) ______-______

EMERGENCY CONTACT NAME AND RELATION TO YOU: ______________________
EMERGENCY CONTACT PHONE NUMBER: (_____) ______-______

PRIMARY PHARMACY: ______________________
PHARMACY ADDRESS: ______________________________

PRIMARY CARE PHYSICIAN: ______________________________

REASON FOR TODAY'S VISIT: ______________________________

____

CURRENT MEDICATION LIST **Please List the Name, Strength and Dosage:**

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

**If More Than Ten Medications, Please Attach a Copy of Your Medication List*

ALLERGIES Please List Any Allergies You Have, **Along with Reaction(s):**

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

PAST MEDICAL HISTORY Please Check All That Apply:

Abuse/ Domestic Violence ___ Acid Reflux (GERD) _____ Anemia _____
Anesthesia Complications ___ Anxiety _____ Arthritis _____
Birth Defects _____ Bladder Incontinence _____ Blood Transfusions _____
Breast Cancer _____ Bowel Incontinence _____ Depression _____
Diabetes _____ Eating Disorders _____ Endometriosis _____
Fibromyalgia _____ GI Problems _____ Headaches/ Migraines _____
Heart Disease _____ Heart Problems _____ Hepatitis _____
High Cholesterol _____ Hypertension _____ Infertility _____
Kidney Disease _____ Kidney/ Bladder Problems ___ Lung Disease _____
Osteoporosis _____ Ovarian Cancer _____ Polyps _____
Psychiatric Illness _____ Stroke _____ Thrombophilia _____
Thyroid Problems _____ Varicosities _____

Other(s):

____

GYNECOLOGIC HISTORY: Please answer ALL questions to the best of your ability; **EVEN IF** you are in menopause or have had a hysterectomy.

LMP (Last Menstrual Period): ______________________
Age at Which Your Cycle First Began: _______
Duration of Menstrual (DAYS): ______________________
Flow: _______ Heavy, _______ Moderate, _______ Light
If Post-Menopausal, Age at Menopause: _______
Current Birth Control Method: ____
Desired Birth Control Method: ____
HPV Vaccinated? _______ YES or _______ NO
Hysterectomy? _______ YES or _______ NO
Sexual Orientation: ___Bisexual ___Heterosexual ___Homosexual ___Transgender
Are You Sexually Active? ______ Yes or ______ No; If yes, how long with current partner? ________________
Experiencing Any Sexual Problems? _______ Yes or _______ No
Lifetime Total # of Sexual Partners: Circle- None, 1-5, 6-10, 11-15, 16-20, Greater Than 20
Sexual Abuse? _______ Yes or _______ No; If yes, currently or in past? ______________________________
Date of Last Pap Smear: ______________________; History of an abnormal Pap? _______ YES or ______ NO
Date of Last Mammogram: ______________________
Date of Last Diagnostic Mammogram: ______________________
Date of Last Breast Ultrasound: ______________________
Date of Last Pelvic Ultrasound: ______________________
Date of Last Bone Density: ______________________
Perform Monthly Self Breast Exams? ______ YES, ______ NO, ______ SOMETIMES
STIs/STDs? _______ YES or _______ NO (Please circle any that apply) Chlamydia, Gonorrhea, Genital Warts Herpes, HIV/AIDS, HPV (Human Papilloma Virus), Syphilis, and Trichomonas (Trich).
Please Check All History That Applies: _______Primary Infertility, _______ Secondary Infertility, _______ Endometrial Polyp, _______ Ovarian Cyst, _______ Fibroids, or _______ Endometriosis.
Have You Had Any Procedure Done by Dr. Whitney Shoemaker? _______ Yes or _______ NO
If Yes, Please List Procedure with Date: ____

OBSTETRIC HISTORY:

Total Number of Times Pregnant: _______

Number of Full Term Births (state vaginal or C-section): ____________________

Number of Preterm Births (state vaginal or C-section): ____________________

Number of Elected Abortions: _______

Number of Miscarriages: _______ If so circle: D&C or D&E Done

Number of Deceased Children (please state age and cause of death): ____________________

Number of Adopted Children: _______

FOR PROVIDER'S USE ONLY: Gravida: ____________ **Para:** ____________

SURGICAL HISTORY Please Check All That Apply with **Year of Procedure Also:**

Appendectomy __________

Back Surgery __________

Breast Biopsy: Right ___ Left ___

Breast Implants __________

Cataracts __________

Colposcopy __________

Colonoscopy __________

Gallbladder __________

Gastric Bypass __________

Heart __________

Hernia Repair __________

Hysterectomy __________

Joint Replacement __________

Mastectomy __________

Thyroidectomy __________

Tonsillectomy __________

Tubal Ligation __________

Other(s):

____

HOSPITALIZATION(S): Please List with Dates and Reasons:

____

____

____

____

IMMEDIATE FAMILY HISTORY Please State Which Family Members and if They are Paternal (Father Side), Maternal (Mother Side), and Age of Diagnosis:

Breast Cancer: ____

Ovarian Cancer: ____

Pancreatic Cancer: ____

Colon Cancer: ____

Prostate Cancer: ____

Other Cancer or Pertinent Family History: ______________________________

____

SOCIAL HISTORY:

Tobacco Use? _______ Yes or _______ No. If Yes, What Kind of Tobacco: ______________________
Used Drugs Other Than Those for Medical Reasons in the Past 12 Months? _______ Yes or _______ No
Did You Have an Alcoholic Beverage in the Last 12 Months? _______ Yes or _______ No
Are You Currently Employed? _______YES; OCCUPATION: ______________________, _______ NO, _______ Retired, or _______ STUDENT.
Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed ___In Relationship with Male Partner ___In Relationship with Female Partner
Living With: ___Alone ___Spouse ___Significant Other ___Family ___Friends
Religious Preference: ______________________
Exercise? ___None ___Occasionally ___Moderate ___Heavy
Diet: ___Regular ___Vegetarian ___Gluten-Free ___Carbohydrate ___Cardiac ___Diabetic
Caffeine Intake: ___None ___ 1-2 Cups Per Day ___ 2-3 Cups Per Day ___ 3-4 Cups Per Day ___ More Than 4 Cups
Blood Transfusion Acceptable? _______Yes or _______No
Advanced Directive? _______Yes or _______No
Occupational Exposure? ___None ___Toxic Chemicals ___Infectious Agents ___Repetitive Physical Stress

UROLOGIC HISTORY:

Have You Ever Had Bladder Surgery? ______ Yes or ______ No. If So, What Kind? ______________________
Do You Leak Urine When Coughing, Sneezing, Exercising, etc. ______ Yes or ______ No?
Do You have Urgency or Frequency? ______ Yes or ______ No

Notice of Privacy Acknowledgement

Whitney Shoemaker, DO, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change it Notice of Privacy Practices and that I may contact at any time to obtain a current copy of the Notice of Privacy Practices.

______________________________ ______________________
Patient Name or Legal Guardian (Print) Date

____
Signature

OFFICE USE ONLY

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:
Date: ______________________ Attempt: ______________________

Staff Name: ______________________

Whitney Shoemaker, DO, LLC
598 Sterthaus Drive, Ormond Beach, FL 32174
Office: (386) 256-2565 - Fax: (386) 256-2567

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ______________________ Date of Birth: ____________

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations to Receive Medical Records:

______________________ ______________________

______________________ ______________________

______________________ ______________________

The patient or the patients' representative must read and initial the following statements:

1.	I understand that this authorization will expire on __/__/____ (MM/DD/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy	
3.	I understand that my healthcare and the payment for my health care will no be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed at patient request.	
5.	If I have any questions about disclosure of my health information, I can contact the office staff or the physician.	

______________________ ______________________

Signature of Patient or Legal Representative Date

______________________ ______________________

If Signed by Legal Representative, Relationship to Patient Signature of Witness

THIS DOCUMENT WILL BE RETAINED BY THE PROVIDING ORGANIZATION FOR SIX YEARS

THE GYNECOLOGY CENTER
598 Sterthaus Drive
Ormond Beach, FL 32174

Thank you for choosing The Gynecology Center as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our policy, which requires that you read, initial, and sign prior to any treatment and/or seeing the Dr. Shoemaker.

PATIENT CONSENT AND AUTHORIZATIONS

_____ Initials **CONSENT FOR TREATMENT:** I, the undersigned patient, parent or legal guardian, do hereby present myself (or the patient) for care or treatment at The Gynecology Center and voluntarily consent to the rendering of such care or treatment, including performance of diagnostic and/ or surgical procedures. I understand that I am under the same care and supervision of my physician and it is the responsibility of the practice and its staff to carry out at the instructions of the physician. I understand the physician expects payment in full upon receipt of a bill. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the office. I understand that I am responsible for the outcomes of care or treatment if I do not follow the care, service, or treatment plan.
A MEDICALLY INDICATED EXAMINATION INCLUDING BUT NOT LIMITED TO A PELVIC EXAM

_____ Initials **ASSIGNMENT OF BENEFIT:** I hereby assign payment directly to The Gynecology Center of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges which the insurance carrier declines pay.

_____ Initials **RELEASE OF MEDICAL INFORMATION:** I, the undersigned patient, parent or legal guardian, do hereby authorize The Gynecology Center, its office and employees, to release any third party payer (such as an insurance company or government agency; example: Blue Cross Blue Shield, Medicare, Social Security/Disability) any medical, psychiatric, alcohol, drug use, and/or HIV (AIDS and AIDS related complex) treatment information and r ecords, in accordance with the policy of The Gynecology Center and any applicable State or Federal Statutes, concerning diagnosis and treatment for the above admission when requested by such third party payer for its use in connection with determining a claim for payment for such care, treatment, and/or diagnosis. I authorize the release of any and all medical liability that may arise from the release of the information requested.

_____ Initials **MEDICARE BENEFICIARY-NOTICE OF NON-COVERED SERVICES:** Medicare does not cover some inpatient, outpatient, and emergency services. Items not covered include but are not limited to, some medications, annuals, and physicals. My initials and signature below only acknowledges my receipt of this message from The Gynecology Center as dated below and does not waive my right to request a review or make me liable for any payment.

_____ Initials **FINANCIAL AGREEMENT:** The undersigned agrees, as a patient or agent, she individually hereby obligates herself to pay the account of The Gynecology Center physician in accordance with the regular rates and terms of the physician. The undersigned will pay all costs and expenses including reasonable collection fees (which may include agency, attorney, interest or court fees) incurred or paid by The Gynecology Center in collection of this obligation by suit or otherwise. The Gynecology Center accepts cash, checks, credit cards (VISA, MasterCard, and Discover), and care credit.

_____ Initials **CANCELLATIONS:** For future appointments, there will be a $45 cancellation/no show fee charged unless 24 hour notice is given to the office prior to the appointment. If your appointment is not canceled and you do not show to your scheduled appointment, $45 will be charged to your account. Of course we realize emergencies occur so please notify us as soon as possible.

______________________ Patient Name	______________________ Date
______________________ Patient Signature	______________________ Indicate Relationship If Representative

FLORIDA LAW: Section 817.234 Florida Statues stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, misleading information is guilty of a felony of the third degree.

Dr. Whitney Shoemaker

The Gynecology Center

Pelvic Examination Informed Consent

I understand by law my health care practitioner requires written informed consent to perform a Pelvic Examination on me. I have been informed that I will be receiving a Pelvic Examination.

Description of Examination

A "Pelvic Examination" means an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum or external pelvic tissue or organs using any combinations of modalities which may include, but may not be limited to, the health care provider's gloved hand or instrumentation as well as that of a student as this is a teaching facility.

I have been informed as to the nature and process of the Pelvic Examination. Any and all questions have been answered to my satisfaction.

I hereby GIVE MY INFORMED AND VOLUNTARY CONSENT to receive a pelvic examination.

______________________________ ______________

Patient's Name (printed) Date of Birth

______________________________ ______________

Patient or Parent/ Authorized Healthcare Surrogate Signature Date

____

Relationship to Healthcare Surrogate

____

Printed Name of Parent/ Authorized Healthcare Surrogate

Dr. Whitney Shoemaker
THE GYNECOLOGY CENTER

Ormond Beach, FL 3217
Ph: (386) 256-256
Fax: (386) 256-256

BILLING GUIDELINES

Listed below are our billing guidelines. Please read the information and sign this sheet.

1. We will collect your deductible or co-pay responsibility at the time of service. Please be prepared to pay by cash, check, Visa, MasterCard, debit card or Care Credit.
2. Please be thorough with your insurance information. We will need to make a copy of all insurance cards.
3. As a courtesy, we will file your insurance. We file electronically on a daily basis, so prompt payment is expected from your insurance company.
4. Your insurance will send you an explanation of benefits that explains what they have paid to our office. You must keep this record on file. If you do not agree with the insurance payment, please contact the insurance company
5. If the insurance denies payment, you will be asked to pay in a timely manner.
6. To all Medicare patients: We participate as Medicare providers. We will file Medicare and your secondary insurance.
7. HMO or PPO patients requiring a referral: You are responsible for making sure your first visit and all follow-up visits with our office are authorized by your primary care physician. This is not our policy, but the policy of your insurance company If the insurance denies due to lack of authorization, the bill is your responsibility
8. Self-pay patients: payment for medical services is due at the time of service. Be prepared to make a payment.
9. There may be time when the doctor requests laboratory tests that we do not perform in our office. If you get a bill from the outside laboratory, please contact the number listed on the bill to resolve any billing problems. They do their own billing.

****If you have any questions regarding our financial policy, please call our office at 386-256-2565 and ask for billing****

I have read this document and understand the information included therein.

______________________________ ______________________
Patient Signature Date