PrimeOBGYN
Commitment. Compassion. Communication.

New Patient Information Packet

We are so delighted that you have chosen us as your physicians! In preparation for your first visit, we would appreciate your help in gathering your medical history. It is important for us to obtain this information prior to your first visit, so that we may use your visit to focus on you, and any issues that you may need addressed. We realize that the forms are looooooooonnnnggg, but please be thorough in your responses, and be sure to include your name on each page. Should you find any questions confusing, please circle the answer line, so that we may review that question with you during your visit. ***Please promptly return this form prior to your visit, preferably by email or fax*** (sure, we'll accept in person, or "regular" mail).

- Fax (407) 649-4302
- E-mail registration@PrimeOBGYN.org
- Mail or deliver to 1111 S. Orange Avenue, 4th Floor
  Orlando, FL 32806

The next-to-last page is a brief summary of your insurance information, and the last page of this document is a medical records release that you should forward to your previous doctor to obtain your records. Many practices produce paper photocopies of records, which are often difficult to read. We prefer an electronic (PDF) version of your records, which you are entitled to request. Ask your provider to email the records directly to you (so that you may have a copy), and then forward them to the above address.

Please visit us on the web at www.PrimeOBGYN.org
or on Facebook at www.Facebook.com/PrimeOBGYN

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Please write your name	Your birth date

Past Medical History (Please circle if you have had any of the following)

Anemia	Hepatitis A	Kidney Stones	Chlamydia
Arthritis	Hepatitis B	Osteopenia	Gonorrhea
Asthma	Hepatitis C	Osteoporosis	HIV
Diabetes Type1	Hypertension	Clot in lungs	Herpes, oral
Diabetes Type2	Hyperthyroid	UTI (chronic)	Herpes, genital
Clot in Leg	Hypothyroid	Endometriosis	PID
Heart attack	Migraine	Fibroids	Syphilis
Blood in Urine	Mitral Valve		
……..(chronic)	……..Prolapse		

Any Cancer? (list details)

Other Medical (list details)

Past Surgical History Please circle if you have had any of the following:

Appendectomy	Hysterectomy	Removal of ovary
Tubal ligation	Hysteroscopy	…..(right, left, both)
Tubal reversal	Laparoscopy	Partner Vasectomy
Cesarean Section	Myomectomy	Removal of tube(s)
Gall Bladder Removal		…..(right, left, both)
D&C		VBAC
Endometrial Ablation		

Other Surgery (list details)

Pap Smear History (Please circle appropriate choices)	Year	Additional Info
Never had a pap smear	_____	
Never had an abnormal pap smear	_____	
HPV Test positive	_____	
Pap smear with mild dysplasia (pre-cancer), not treated	_____	
Pap smear with mild dysplasia (pre-cancer), treated	_____	
Pap smear with severe dysplasia (pre-cancer), treated	_____	
Cryotherapy (freezing of cervix)	_____	
Cone Biopsy	_____	
LEEP Procedure	_____	
Other	_____	

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Please write your name	Your Birth Date

Please List Any Medications That You Currently Take

Please include prescription medications, over-the-counter medications, and herbals.

Drug Name	Dose	How Often?

Please List Allergies (Include Medications, Foods, and Environmental Allergies)

Drug Name	Reaction	Food Name	Reaction	Environmental Name	Reaction

Family Medical History Please circle if anyone in your family has had the following:

Breast Cancer	Ovarian Cancer	Colon Cancer
Mother under 50 Mother over 50 Sister under 50 Sister over 50 Daughter Other (list)	Mother Sister Daughter Other (list)	Mother under 50 Father under 50 Sibling under 50 Mother over 50 Father over 50 Sibling over 50 Other (list)

Additional Family History	Please list family members affected
Bleeding disorder	
Colonic Polyps	
Diabetes	
Clots in legs	
Heart Disease	
High cholesterol	
Hypertension	
Mental Retardation	
Osteoporosis	
Clots in lungs	
Sickle cell anemia	
Stroke	
Thalassemia	

Additional Family History

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Please write your name	Your Birth Date
Genetic History	Please list family members affected
In-Born Heart Defect	
Cystic Fibrosis	
Down Syndrome	
Hemophilia	
Mental Retardation	
Muscular Dystrophy	
Spinal Muscular Atrophy	
Spina Bifida	
Sickle Cell Disease	
Tay-Sachs	
Thalassemia	
List any other inherited disease and family member affected	

Menstrual History (complete as many as relevant to your age)
Age first period:_____

Age of Menopause (if post menopause):_____

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Please write your name	Your birth date

Pregnancy History (please circle --- none --- if never pregnant)

Baby Birth Date (Year only for losses)	Weeks or "full term"	Birth Weight	Sex	List Vaginal, Forceps, Vacuum, Cesarean, VBAC, Abortion, Miscarriage, Ectopic	Pre Term Labor?	Complications? (list below)
			M/F		Y / N	
			M/F		Y / N	
			M/F		Y / N	
			M/F		Y / N	
			M/F		Y / N	
			M/F		Y / N	
			M/F		Y / N	

Social History Please circle appropriate answer(s)

Tobacco	Alcohol
Daily Some Days Former Never	Daily Some Days Former Never
Marital Status	**Exercise**
Dating Divorced Engaged Married Not-Dating Single Widowed	Active, no formal exercise Heavy (more than 4x week) Moderate (1-3x week) Minimal (1x week) Sedentary

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Insurance Registration

First Name	
Last Name	
Last Name (on your insurance card if different from above)	
Date of Birth	
Social Security Number	
Race (required by Affordable Care Act)	
Ethnic Group (required by Affordable Care Act)	
Home Street Address	
City, State, Zip Code	
Home Phone (or none)	
Work Phone (or none)	
Cell Phone (or none)	
E-mail	
Insurance Company	
ID Number	
Group Number	
Provider Contact Number (on back of card)	

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AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ **D.O.B.:** _____ **SS#** _____

Medical Records To:

PrimeOBGYN, P.A.

Address: 1111 South Orange Ave, 4th Floor

Orlando, Florida 32806

Phone: 407-649-4300

Fax: 407-649-4302

Medical Records From:

_____

Address:

_____

_____

Phone:

_____

Information to be released:

- ☐ All medical information and reports
- ☐ Prenatal medical records
- ☐ Physical examination reports
- ☐ Laboratory reports
- ☐ Immunizations
- ☐ Radiology (x-ray/ultrasound) reports
- ☐ Sexually transmitted testing reports
- ☐ Psychiatric/psychological reports
- ☐ HIV/AIDS test results
- ☐ Other (please specify)_____

Purpose for release:

- ☐ Continuation of care
- ☐ Transfer of care to another physician or hospital
- ☐ Personal copy
- ☐ Location/Moved
- ☐ Referral to another physician
- ☐ Other (please specify)_____
  _____

Please specify anything that you do NOT want to be released:

_____

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse, and/or HIV/AIDS test results. I expressly consent to the release of information as designated above, which may be transmitted by mail, email, fax, or other electronic transmission.

I understand that this authorization will remain in effect for one year unless otherwise specified. I understand that this authorization is revocable upon written notice where the original authorization is retained. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I understand that after signing this for, there is a processing period of up to 5 business days.

Patient/Legal Representative or Parent/Legal Guardian Date

FEE FOR COPYING RECORDS TO PAPER: $1.00/page up to 25 pages - 25-100 pages = $25.00 - 100+ pages = $35.00
Authorization must be signed and payment received before any chart will be copied.

THERE WILL BE NO FEE FOR CREATING AN ELECTRONIC COPY OF RECORDS PROVIDED BY PRIMEOBGYN, P.A.