NORTH FLORIDA OB GYN, LLC

FIRST NAME ______________ LAST NAME ______________ MI ___ DOB ___/___/___ AGE ____ DATE ___/___/___
ADDRESS ______________ DAYTIME # ______________ ALTERNATE # ______________ RACE __________
REASON FOR THIS APPOINTMENT ______________________________

MENSTRUAL HISTORY:

FIRST DAY OF YOUR LAST PERIOD ___/___/___
WAS IT NORMAL FOR YOU? ☐NO ☐YES
HOW LONG DO THEY LAST? ________ DAYS
HOW MANY DAYS IS YOUR CYCLE (FROM START TO START)? _______ DAYS
HOW OLD WERE YOU WHEN YOU STARTED YOUR PERIODS? ______ YRS. OLD
PAIN/CRAMPS? ☐NO ☐YES

BLEEDING BETWEEN PERIODS ☐NO ☐YES
VAGINAL DISCHARGE ☐NO ☐YES
VAGINAL ITCHING ☐NO ☐YES
PAIN WITH INTERCOURSE ☐NO ☐YES
BLEEDING WITH INTERCOURSE ☐NO ☐YES

OBSTETRICAL HISTORY:

HOW MANY TOTAL PREGNANCIES HAVE YOU HAD? _______
HOW MANY CHILDREN DID YOU DELIVER? _______
HOW MANY MISCARRIAGES HAVE YOU HAD? ______

BIRTH CONTROL METHOD: (CIRCLE ONE)

PILLS (NAME) ______________ DEPO-PROVERA
NORPLANT CONDOMS DIAPHRAGM SPERMICIDES
VASECTOMY ABSTINENCE TRYING TO CONCEIVE
OTHER ______________________________

DO YOU HAVE OR EVER HAD:

☐DIABETES
☐HEART PROBLEMS
☐HIGH BLOOD PRESSURE
☐KIDNEY/BLADDER PROBLEMS
☐LUNG PROBLEMS
☐CANCER (TYPE ______________)
☐NERVOUS BREAKDOWN
☐SHORTNESS OF BREATH
☐VISUAL DISTURBANCES
☐CHLAMYDIA
☐GONORRHEA
☐GENITAL HERPES
☐HPV (HUMAN PAPILLOMA VIRUS)
☐PNEUMONIA
☐POLIO OR MENINGITIS
☐GALL BLADDER DISEASE
☐LOSS OF BLADDER CONTROL
☐SWELLING OF HANDS/FEET
☐JAUNDICE
☐ANEMIA
☐EPILEPSY
☐CONVULSIONS
☐CHEST PAIN
☐NIGHT SWEATS
☐FAINTING SPELLS
☐SKIN DISEASE
☐CHRONIC COUGH
☐VEIN PROBLEMS
☐STOMACH TROUBLE
☐BOWEL PROBLEMS
☐RECTAL BLEEDING
☐HEADACHES
☐THYROID TROUBLE
☐HEPATITIS
☐OTHER ______________

MEDICATION:
ARE YOU ALLERGIC TO ANY MEDICATIONS ☐NONE KNOWN ☐YES
IF SO WHAT NAME AND WHAT REACTION? ______________________________
WHAT ARE YOU CURRENTLY TAKING (RS & OVER THE COUNTER)? ______________________________

VACCINATIONS: (WHEN) INFLUENZA ______________ GARDASIL ______________ PNEUMOVAX ______________

SURGERIES: (WHEN, WHAT, WHY) ______________________________
____

SOCIAL HISTORY:
MARITAL STATUS ☐ MARRIED (HOW LONG _____) ☐SINGLE ☐ DIVORCED ☐WIDOWED
USE OF ALCOHOLIC BEVERAGES ☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ NEVER
DO YOU SMOKE? ☐NO ☐YES HOW MANY PER DAY __________ HOW LONG? __________

PAP SMEAR HISTORY:
WHEN WAS YOUR LAST PAP? ___/___/___ ☐ NEVER WAS IT NORMAL? ☐NO ☐ YES
HAVE YOU EVER HAD AN ABNORMAL ONE? ☐NO ☐ YES WHAT? ______________

MAMMOGRAM HISTORY:
WHEN WAS YOUR LAST MAMMOGRAM? ___/___/___ ☐ NEVER WAS IT NORMAL? ☐ NO ☐YES
HAVE YOU EVER HAD BREAST PROBLEMS? ☐ NO ☐YES WHAT? ______________

FAMILY HISTORY: (HAS ANY OF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING)

	WHO		WHO
☐DIABETES	______________	☐HEART TROUBLE	______________
☐HIGH BLOOD PRESSURE	______________	☐KIDNEY TROUBLE	______________
☐LUNG DISORDER	______________	☐CANCER (BREAST, OVARIAN, UTERINE ,COLON, ETC.)	______________

OFFICE USE ONLY

G ________ P ________ A ________ BP _____/______ WT _______LBS HT ________ UA ______________________________

REMARKS:

North Florida OB GYN LLC

Confidential Patient Information Form - Form must be filled out completely to ensure correct claim processing.

Social Security ___________________**Patient** ____
(*Last*) (*First*) (*Middle Initial*)

Date of Birth_________________**Address**____
(Street #) (City) (State) (Zip)

Home Tel#: _________________________**Work Tel#:** ______________________**Patient Cell #** _________________________

(If Cell # is provided, the office may text you appointment reminders) **Employer**_________________________________

Patient E-Mail___________________________ **Marital Status** ______________ **Employment Status** __________________
(S M D W Sep) (*FT PT Ret N*

How did you hear about our office? ____**Student**___________ *(FT PT)*

Referring Physician _________________________________**Primary Care Physician** __________________________________

Emergency Contact _______________________________ **Relationship**__________________ **Phone #** ___________________

Spouse's name or other responsible party:__________________________________ **Phone #** ___________________________

Pharmacy Name, Phone #, Fax # and address____

Primary Insurance: _______________________**Subscriber (Insured) Name** ____________________________________

Subscriber: Date of Birth_________________ Social Security # ___________________________Employer____________________

ID#____________________ **Group Name & #**________________________ **Patient Relationship to Insured**_______________
(Self, Spouse, Child)

Insurance Address____
(City) (State) (Zip)

Second Insurance: ________________________ **Subscriber (Insured) Name**___________________________________

Subscriber: Date of Birth___________________ Social Security # ___________________________Employer__________________

ID#____________________ **Group Name & #**________________________ **Patient Relationship to Insured**_________________
(Self, Spouse, Child)

Insurance Address____

I understand that I am directly and primarily responsible to North Florida Obstetrical & Gynecological Associates, P.A., the parent company of North Florida OB GYN, LLC, for its customary fee for the services rendered to me by North Florida OB GYN, LLC. I realize that if my insurance company fails to pay or if there is any delay in paying North Florida Obstetrical & Gynecological Associates, P.A., it is my responsibility to pay my doctor's bill directly. I further understand and agree if I fail to make timely payments to North Florida Obstetrical & Gynecological Associates, P.A., that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s).

For the services rendered by North Florida OB GYN, LLC, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or the party who accepts assignment (North Florida Obstetrical & Gynecological Associates, P.A.). I authorize payment of medical benefits to the physician who submits the claim. I agree to hold North Florida OB GYN, LLC harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent. North Florida OB GYN, LLC and other PA subsidiaries may share one electronic medical record. To facilitate the provision of my medical care, I consent for North Florida OB GYN, LLC to access my medical records maintained by any other PA subsidiary.

I understand the office may employ an Advanced Registered Nurse Practitioner ("ARNP"), Midwife ("ARNP/CNM") or Physician Assistant ("PA"), and if I am scheduled with them, I am willing to see them instead of the doctor. I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I consent to electronic access to my medication history.

This form was last modified on **10/1/2015**. I acknowledge that I have read this authorization and fully understand its contents.

Signature____Date___________________

NORTH FLORIDA OB GYN, LLC
Fellows of the American College of Obstetricians and Gynecologists
3 Shircliff Way, Suite 200, Jacksonville, FL 32204
(904) 384-3699 FAX (904) 384-8529
2363-1 Dunn Avenue, Jacksonville, FL 32218

St. Vincent's I Division
William H. Long, M.D.
Thomas R. Virtue, M.D.
D. Scott Wells, M.D.
Annette Laubscher, M.D.
Tracy Wells, M.D.
C. Leanne Browning, M.D.
David L. Miller, M.D.
X. Annie S. Smith, M.D.
Jeanie Summerville, CNM
Amy Grant, P.A.

Patient: ____

DR.: ____

Date: ______________________________ Time: _____________

LOCATION: Shircliff Way ☐ Dunn Ave. ☐

Dear Patient:

Thank you for choosing our office for your obstetric and/or gynecologic health care. We are enclosing new patient forms to be filled out and returned to us in the enclosed envelope. Please be sure to bring your insurance card and, if your plan requires it, obtain any referrals or prior authorization needed to see us. **We require that you arrive 30 minutes prior to your scheduled visit to allow time for a member of our staff to review your medical history with you. You will need to be rescheduled if you are late.** Please bring a list of any medications you're currently taking and any medical records that may be pertinent. This may require a written request from a previous doctor and should be requested far enough in advance so that they are available at the time of your visit.

We have 2 locations for your convenience. Our main office is at 3 Shircliff Way, Suite 200 of the Dillon Building, which is a part of the St. Vincent's Medical Complex. Parking is available in the first parking garage on the right at a flat rate of $2.00. (If you are using an older GPS, use 1820 Barrs Street as the street name has changed in recent years and Shircliff Way is not recognized by the older GPS systems.) Our satellite location is at 2363 Dunn Avenue on the Northside of Jacksonville.

If your insurance company requires a referral in order to see us, please be sure this is obtained before your visit. YOU WILL NOT BE SEEN WITHOUT A REFERRAL IF YOUR INSURANCE REQUIRES ONE FOR YOUR VISIT. If you have any questions regarding our charges or your insurance, please contact our insurance department at 384-3699.

Thank you again for choosing our practice and we look forward to providing you with the best health care possible.

Sincerely,

NORTH FLORIDA OB GYN, LLC

Directions to Our Riverside Office
3 Shircliff Way
Suite 200, Dillon Building
(904) 384-3699

FROM POINTS SOUTH OF DOWNTOWN

Interstate 95 North to Acosta Bridge - As you approach the downtown area stay in the right hand lanes. Follow the exit signs for Riverside Avenue. Follow Riverside Avenue for approximately 1 3/4 miles. Turn left on Shircliff Way and immediately into the parking garage on your right. The Dillon Building is attached to the parking garage. Our office is on the second floor, Suite 200.

FROM NORTH OF DOWNTOWN

Interstate 95 South to Interstate 10. Go left on Stockton Street for approximately 6-7 blocks. Right on Riverside Avenue. At next traffic light – Shircliff Way take a left. The parking garage is immediately on your right. The Dillon Building is attached to the parking garage. Our office is on the second floor, Suite 200.

WEST OF DOWNTOWN

Interstate 10 East to Stockton Exit. Go left on Stockton Street for approximately 6-7 blocks. Right on Riverside Avenue. At next traffic light - Shircliff Way take a left. The parking garage is immediately on your right. The Dillon Building is attached to the parking garage. Our office is on the second floor, Suite 200.

EAST OF DOWNTOWN

Arlington Expressway to the Matthews Bridge – take State Street to Interstate 95 South to Stockton Street Exit. Go left on Stockton Street for approximately 6-7 blocks. Right on Riverside Avenue. At next traffic light – Shircliff Way take a left. The parking garage is immediately on your right. The Dillon Building is attached to the parking garage. Our office is on the second floor, Suite 200.

FROM BUTLER, ATLANTIC OR BEACH BOULEVARD

Interstate 95 North to Acosta Bridge – As you approach the downtown area stay in the right hand lanes. Follow the exit signs for Riverside Avenue. Follow Riverside Avenue for approximately 1 3/4 miles. Turn left on Shircliff Way and immediately into the parking garage on your right. The Dillon Building is attached to the parking garage. Our office is on the second floor, Suite 200.

Directions to Our Dunn Avenue Office
2363 Dunn Avenue
(904) 384-3699

FROM FERNANDINA BEACH - AMELIA ISLAND

Interstate 95 South to Dunn Avenue exit. Right on Dunn Avenue for 2 miles. At traffic light marked "Pine Estates" put your right blinker on - office entrance approximately 30 yards AFTER light. (Entrance not easily seen until you're right on it!) Our office is a one story, red brick building with Orthodontics written on the sign.

FROM POINTS SOUTH

Interstate 95 North to Dunn Avenue exit. Turn left on Dunn Avenue for 2 miles. At traffic light marked "Pine Estates" put your right blinker on - office entrance approximately 30 yards AFTER light. (Entrance not easily seen until you're right on it!) Our office is a one story, red brick building with Orthodontics written on the sign.

FROM 295 SOUTH

Interstate 295 North to Dunn Avenue. Exit Right. Go approximately 2 miles. After the traffic light marked "Duval Road," we on the left hand side right before the next traffic light "Pine Estates." Our office is a one story, red brick building with Orthodontics written on the sign.

FROM LEM TURNER-CALLAHAN

Take Lem Turner south to Dunn Avenue take a left at the light. Go through the next traffic light Duval Road. We are on the left hand side right before the next traffic light Pine Estates. Our office is a one story, red brick building with Orthodontics written on the sign.