New Patient Registration

Patient's name:_____

Date of birth:_____/_____/_____ Age:_____ Race:_____

Address:_____

City:_____ State:_____ Zip Code:_____

S.S.#:_____-_____-_____ Martital Status:_____

Home Phone#:(_____)_____-_____ Cell#:(_____)_____-_____

Email Address: _____

Referring Doctor's Name:_____

Referring Doctor's #:(_____)_____-_____

Where did you hear about us?:_____

Employer's Name:_____
Occupation:_____Phone#(_____)_____-_____

Card holder's Name:_____
Date of birth:_____/_____/_____ S.S.#:_____-_____-_____

In case of an emergency contact:_____
Relationship:_____ Phone #:(_____)_____-_____
Next of kin for medical decisions:_____ Phone#:(_____)_____-_____

Insurance company:_____ Phone#:(_____)_____-_____
Member #:_____ Group #:_____

Do you have medicare:YES____NO____ Medicare #:_____
Do you have medicaid:YES____NO____ Medicaid #:_____

PAYMENT IS DUE AT THE TIME OF SERVICE. IF YOU ARE UNAWARE OF YOUR FINANCIAL RESPONSIBILITY PLEASE ASK AT THE FRONT DESK OR CONTACT YOUR INSURANCE PROVIDER. PAYMENT ARRAIGNMENTS MUST BE MADE PRIOR TO SERVICES BEING RENDERED.

Signature of patient/Responsible party:_____
I have received my HIPPA notice of privacy practices. DATE:_____

Pharmacy Information / Delivering Results

To help get your prescription to your pharmacy faster, we need you to please fill out the following information:

Pharmacy Name: _____

Phone: Number: _____

Fax Number: _____

Address: _____

_____

In order for us to get your results to you promptly, we would like you to choose ONE of the following:

1. ___ E-mail results _____
2. ___ Phone Call _____
3. ___ Mailed _____

_____

If #2 was the chosen option, would you give one of our staff members' permission to leave a detailed message regarding your results?

Yes: _____ No: _____

Who may we discuss your medical care with? _____

*This may be revoked at any time.

Patient's Signature: _____ Date: _____

GENERAL CONSENT FOR CARE AND TREATMENT

Consent for Medical Care, Treatment, and in office Medical Procedures

I,_____ (circle the applicable designation: Patient / Representative), hereby authorize Dudley Brown, Jr., MD; Erin Bagley, CNM, and staff of Brown Institute for Health and Wellness, LLC to render in office or Hospital Inpatient medical care, Treatment, and/or Medical Procedures. I understand that routine health care is confidential and voluntary and may involve provider office visits which include history taking, examination, administration of medications, laboratory test, and/or minor procedures. I understand that I may discontinue services at any time.

x_____

Signature of Patient / representative Date

x_____

Witness Date

Patient Financial Responsibility Statement

Financial responsibility rests between you and your health plan. We are pleased to file your claim to your medical insurance, however we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility to pay the denied amounts in full.

All fees are due when the services are rendered. We accept Cash and Debit cards with no additional fee.

CREDIT CARD FEES:
Refunds must be processed on the original form of payment. If that is no longer available the following fee will apply to a check refund:

- 3% On Visa, Mastercard
- No charge for Debit Cards or Cash
  ***WE DO NOT ACCEPT AMERICAN EXPRESS OR DISCOVER CARDS**

WELLNESS EXAMS:
The annual well exam consists of:

- A general gynecological exam. (breast and pelvic examination)
- A pap smear test
- Renewal of current medications, including contraceptive/hormone replacement\

The well-woman exam only is covered at 100%, if you have no problems, complaints, or symptoms. If you have a specific complaint or problem that needs to be addressed, please be aware that additional charges will apply in accordance to your health insurance benefits.

MISSED APPOINTMENTS:

- Office visits/ultrasounds: cancelation/reschedule notice must be given 24 hours prior to the appointment or a $50 fee will be incurred.
- In-office procedures: cancelation/reschedule notice must be given 48 hours prior to the appointment or a $250 fee will be incurred.
- Hospital Surgeries: cancelation/rescheduling/location change will incur a $250 fee.

PAPERWORK:

- ***All paperwork requiring completion and/or a Doctor's signature will be subject to a $25 charge due prior to completion***. This includes but is not limited to FMLA, Short-term disability, etc. We also require a 48 hour turnaround time to complete paperwork.
- Additionally, there will be a charge for printed medical records. Those fees are $1.00 per page up to 10 pages, then $.50 for every page after.

Patient Affirmation:
I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier. I also understand I must pay for my care at the time of service. I authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier or other third party payer for services rendered.

_____ _____ _____

Patient Name (Print) Date Patient Signature

Disclosure of Malpractice Nonparticipation

Florida State Statue 458.320 requires your physician to inform you that he has decided not to carry malpractice insurance. I acknowledge and understand that Dr. Dudley Brown, Jr. does not carry malpractice insurance. Being fully informed of this fact, I choose to continue to receive medical services and/or consultations from the Brown Institute for Health and Wellness, LLC.

_____ _____

Signature Date

_____ _____

Parent or Guardian if patient is a minor Witness

REVIEW OF SYSTEMS

PATIENT:_____DOB:_____

Do you now or have you had any problems related to the following systems? Circle Yes or NO.

GENERAL:

Have you gained or lost weight recently? Y N

How many pounds? _____

NEUROLOGICAL:

Trouble sleeping Y N

Headache Y N

Seizures Y N

ENDOCRINE:

Excessive thirst Y N

Too hot/cold Y N

Tired/sluggish Y N

GASTROINTESTINAL:

Abdominal pain Y N

Nausea/vomiting Y N

Indigestion/heartburn Y N

CARDIOVASCULAR:

Chest pain Y N

Varicose veins Y N

High blood pressure Y N

Other Y N

INTEGUMENTARY:

Skin rash Y N

Nipple discharge Y N

Persistent itch Y N

GENITOURINARY:

Urine retention Y N

Painful/frequent urination Y N

Vaginal discharge/itching Y N

Blood in urine Y N

Pain during/after sex Y N

Irregular menstruation Y N

Clotting/Heavy Periods Y N

RESPIRATORY:

Asthma Y N

Frequent cough Y N

Shortness of breath Y N

Other Y N

HEMATOLOGIC/LYMPHATIC:

Swollen glands Y N

Blood clotting problems Y N

Anemia Y N

PSYCHIATRIC:

Are you happy with life Y N

Do you feel severely depressed Y N

Have you considered suicide Y N

REVIEWED BY:_____

DATE:_____

New Patient Obstetrics & Gynecology Form

This will become part of your medical record. Today's Date:

Name: Date of Birth: Age:

Primary Care Physician: Telephone:

Pharmacy: Pharmacy Address:

Menstrual History:

First day of last menstrual period

Age at first menstrual period years

Number of days from the start of one period to the start of the next days

Number of days that you bleed days

Describe the amount of menstrual flow (circle one) light / moderate / heavy / clots

How many tampons or pads do you use on your heaviest day?

Describe the amount of menstrual discomfort (circle one) none / mild / moderate / severe

Do you bleed in between your periods? Yes ☐ No ☐

Do you bleed after intercourse? Yes ☐ No ☐

If you stopped menstruating, at what age did you stop? years

Have you had bleeding or spotting since your periods stopped? Yes ☐ No ☐

Contraceptive and Sexual History:

Present birth control method:

Birth control methods used in the past:

METHOD	LENGTH OF USE	REASON FOR DISCONTINUATION
1)		
2)		

Have you ever been sexually active (had intercourse)? Yes ☐ No ☐

Have you had a new sexual partner in the past three months? Yes ☐ No ☐

How many sexual partners have you had in the past 3 months?

Is/Are your partner(s) male, female, or both? Male ☐ Female ☐ Both ☐

Do you experience pain or discomfort with sexual intercourse? Yes ☐ No ☐

Would you like to discuss sexual activity or birth control today? Yes ☐ No ☐

Gynecological History:

Have you been vaccinated for Human Papilloma Virus (HPV) – Gardasil Yes ☐ No ☐

Last Pap Smear

Last Mammogram

Last Bone Density (DEXA)

Last Colonoscopy

Have you ever been on hormone therapy (estrogen / progesterone)? Yes ☐ No ☐

Any personal history of:

Abnormal Pap Smears Yes ☐ No ☐

Sexually transmitted diseases Yes ☐ No ☐

List:

Fibroids Yes ☐ No ☐

Endometriosis Yes ☐ No ☐

Infertility Yes ☐ No ☐

Urinary incontinence Yes ☐ N ☐

Obstetrical History: Please record the number of:

Pregnancies ..... Vaginal Births C-Sections ..... Ectopics ..... Abortions .....

Living Children .....

Miscarriages .....

List any complications of pregnancies

Medical History: Please check if you or a blood-relative have had any of the following:

	MYSELF	FAMILY
Anemia	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Heart Disease	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
COPD / Emphysema	☐	☐
Asthma	☐	☐
Seizures	☐	☐
Thyroid problems	☐	☐
Mental Illness	☐	☐
Depression, Anxiety	☐	☐
Eating disorder	☐	☐
Migraine Headaches	☐	☐
Urinary Tract Infection	☐	☐
Lupus	☐	☐
Arthritis, Back Injury	☐	☐
Osteoporosis	☐	☐
Liver Disease / Hepatitis, Gall Bladder Disease	☐	☐
Blood clots in veins/lungs	☐	☐
Blood Transfusion	☐	☐
Breast Cancer	☐	☐
Colon Cancer	☐	☐
Uterine Cancer	☐	☐
Ovarian Cancer	☐	☐
Other Cancer, specify:		

Other Medical Problems (list all):

Surgical History: Please list any operations, including the year, or your age when you had it:

Personal / Social History:

Occupation

Marital Status

Do / Did you use tobacco products? ☐ Yes ☐ No How much?

Do / Did you drink alcohol? ☐ Yes ☐ No How many drinks per week?

Do / Did you use illicit/street drugs? ☐ Yes ☐ No Which drugs?

Have you ever been tested for HIV? ☐ Yes ☐ No Year and result: Have you

Have you ever been a victim of physical, verbal, emotional or sexual abuse? ☐ Yes ☐ No

List any medications you take, including over-the-counter medicines

MEDICINE	DOSE	HOW OFTEN	MEDICINE	DOSE	HOW OFTEN

Please list any allergies to medications:

Is there any other information you feel we should have?

Patient Signature Date Provider Signature

Brown Institute for Health and Wellness, LLC
3375 Burns Rd., Suite 108, Palm Beach Gardens, FL, 33410,
Telephone: (561) 459-8955 ~ Fax: (561) 459-8956

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:_____ ID Number: _____

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 providing the information:	**Persons/organizations receiving the information:**
Specific description of information (including dates):	**Purpose of requested use or disclosure:**

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

		Initials
1.	I understand that this authorization will expire on____/___/___(DD/MM/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 not 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.	
5.	If I have 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.