

**PATIENT
REGISTRATION**

WOMEN'S HEALTH PARTNERS, LLC

DIPLOMATES OF THE AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY

www.myobgynoffice.com

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|--|--|---|--|--|
| <input type="checkbox"/> Samuel Kaufman MD | <input type="checkbox"/> Jane Rudolph MD | <input type="checkbox"/> Lauren Feingold DO | <input type="checkbox"/> Kristine Tibavisky MD | <input type="checkbox"/> Terry DeFilippo CNM |
| <input type="checkbox"/> Stewart Newman MD | <input type="checkbox"/> Gostal Arcelin MD | <input type="checkbox"/> Rachel Ciaccio MD | <input type="checkbox"/> Hara R. Berger, DO | <input type="checkbox"/> Rachel DeVaney CNM |
| <input type="checkbox"/> Susan Beil MD | <input type="checkbox"/> Melissa Friedman MD | <input type="checkbox"/> Masha Sachenko MD | <input type="checkbox"/> Tara Ruberg, MD | <input type="checkbox"/> Laurie Gibbons CNM |
| | | | | <input type="checkbox"/> Tyler Halvaksz CNM |

PATIENT INFORMATION:

Today's Date: _____

Patient Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell: _____ Work: _____

E-mail: _____

Preferred method of communication: _____ Preferred Name (Nick Name): _____

May we leave messages on your answering machines? Yes No

May we send you our quarterly medical newsletter via email? Yes No

For Medical Purposes: Race: _____ Religion: _____ Ethnicity: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Occupation: _____

- REFERRED BY:** Friend Relative Physician Insurance Company
 Reputation of our office By an existing patient Other

Name: _____

EMERGENCY CONTACTS 1:

EMERGENCY CONTACTS 2:

Name: _____

Name: _____

Phone Number: _____

Phone Number: _____

Relationship: _____

Relationship: _____

May we share your medical information with this contact? Yes No

May we share your medical information with this contact? Yes No

MEDICAL INFORMATION:

Primary Care Physician: _____ Phone #: _____

PREFERRED PHARMACY INFORMATION: (used so that we can send electronic prescriptions to your pharmacy)

Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

City: _____ State: _____ Zip Code: _____

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IMPORTANT NOTICES

Claims Processing

I authorize the release of any medical information necessary to process my claims.

I also authorize payment of medical benefits to physician or supplier of service as indicated on claim.

In the event it is necessary to refer my account to a collection agency or an attorney, I agree to pay all collection costs, including attorney's fees and our costs.

Initial _____

Use of MEDICAL RECORDS

I have received a copy of the HIPAA privacy notice explaining how my medical information can be used.

Risks and Responsibility

I understand that all medical care and treatment has some risks and side effects. I will make my decisions about treatment with those risks in mind and agree not to hold my physician, midwife, or any employee of Women's Health Partners liable for such side effects or adverse outcomes from treatment.

I understand that all tests such as mammograms; pap smears, blood tests, and others have some degree of error and do not guarantee that I am free of disease.

I also agree and understand that it is my responsibility to follow and perform tests as ordered by my healthcare provider, to be aware of the results, and to schedule and keep appointments for follow up as directed by my physician, midwife, or other employee of Women's Health Partners.

Insurance Notice

Under Florida law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice.

This notice is pursuant to Florida Law.

I have carefully read and understand all of the above statements:

Signature

Date