PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT NAME_____ SOCIAL SECURITY _____-_____-_____

ADDRESS _____CITY/STATE_____ZIP CODE_____

DATE OF BIRTH_____/_____/_____ EMAIL_____

MARTIAL STATUS _____ RACE _____ HOME PHONE (_____)_____

ETHNICITY_____ WORK (_____)_____

EMPLOYER _____ CELL (_____) _____

REFERRING PHYSICIAN _____HOW DID YOU HEAR OF US? _____

EMERGENCY CONTACT NAME _____ PHONE _____

INSURANCE

PLAN NAME_____

ID NUMBER _____ GROUP NUMBER _____ PT RELATIONSHIP _____

POLICY HOLDER _____ _____POLICY HOLDER DATE OF BIRTH _____/_____/_____

POLICY HOLDER SOCIAL SECURITY NUMBER _____-_____-_____

SECONDARY INSURANCE

PLAN NAME_____

ID NUMBER _____ GROUP NUMBER _____ PT RELATIONSHIP _____

POLICY HOLDER _____ _____POLICY HOLDER DATE OF BIRTH _____/_____/_____

POLICY HOLDER SOCIAL SECURITY NUMBER _____-_____-_____

PERSON RESPONSIBLE FOR BILL OR PARENT (COMPLETE IF DIFFERENT FROM PATIENT)

GUARANTOR NAME _____ SOCIAL SECURITY NUMBER _____-_____-_____

RELATIONSHIP TO PATIENT (PLEASE CK): ( ) SELF, ( ) SPOUSE, OR ( ) PARENT DATE OF BIRTH_____/_____/_____

ADDRESS _____ PHONE NUMBER _____

EMPLOYER NAME _____ EMPLOYER PHONE NUMBER (_____)_____

EMPLOYER ADDRESS _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

AND/OR

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

X_____
PATIENT OR PARENT (if a minor)

X_____
DATE

HALIFAX OB/GYN ASSOCIATES
GYNECOLOGY AND OBSTETRICS

Thomas G. Stavoy, MD., F.A.C.O.G. * Pamela P. Carbiener, MD., F.A.C.O.G. * Stephen J. Cortez, MD. F.A.C.O.G * Cynthia Baldwin, MD., F.A.C.O.G. *Marjorie Bhogal, MD*Patricia Esquivel, MD* *Laura B. Bell, CNM *

To Our Patients:

As you know, if you have ever checked into a hotel or rented a car the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company since it makes checkout easier, faster, and more efficient. We have implemented a similar policy. You will be asked for a credit card number at the time you check in and this information will be held securely until your insurance company has paid its portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card and a copy of the charge will be mailed to you. We accept Visa, Mastercard, Discover and American Express.

Again, this will be an advantage for you since you will no longer have to write a check and mail it to us. It will be an advantage for us as well since it will greatly reduce the number of statements we have to generate and send out. This combination will benefit everyone, helping to keep the cost of health care down. In no way will it compromise your ability to dispute a charge or question your insurance company's determination of payment. Co-pays due at this time of visit will, of course, still be due at that time.

If you have any questions about this method of payment, please do not hesitate to ask us.

Sincerely,

Halifax OB/GYN Associates

I authorize Halifax OB/GYN Associates to charge my credit card to pay any balances due on my account after my insurance company has processed my claim(s), or any balance owed to Halifax OB/GYN Associates which would also include No show fees.

Print Name on Card:_____

Signature of Card Holder:_____Date Signed_____

Credit Card#:_____Exp._____

Security Code (on back of card)_____

Email address_____

DEBIT VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Revised 04-29-15

HALIFAX OB/GYN ASSOCIATES
Florida Woman Care, LLC

CONSENT FOR TREATMENT

As with any medical procedure, there is some risk involved. I hereby give consent to Halifax OB/GYN Associates to provide whatever treatment the assigned physician may deem necessary to the patient named.

_____ _____
Patient/Responsible Party Signature Date

CONSENT FOR TREATMENT OF MINOR CHILD

I hereby authorize Dr. _____and/or his/her staff to examine and/or treat my

_____
Indicate Relationship and First Name of Child

_____
Full Name of Child

_____ _____
Patient/Responsible Party Signature Date

_____
Witness

Rev. 03112005

HALIFAX OB/GYN ASSOCIATES
GYNECOLOGY AND OBSTETRICS

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IMPORTANT INFORMATION REGARDING INSURANCE BILLING

Our doctors are here to provide you with the best medical care. Their primary concern is your health and well-being, not with your insurance company. Therefore, it is the patient's responsibility to be aware of what their policy covers.

It is very important for you to read your insurance policy carefully. Some insurance companies do not cover annual gynecologic visits while others will only cover certain specific problems. As we participate with numerous insurance companies and each company has many different plans, we cannot possibly be aware of each patient's particular coverage. We will bill your insurance company for exactly the provedures done in the office. You will receive a bill if the service is one that is not covered under your policy. It is very important that you are familiar with the benefits and policies of your insurance.

You will be asked at your visit which lab you would like Pap smears and cultures to be sent to and the nurses will note the name of the lab in your chart. It is very important that you check your insurance policy to see which lab they participate with. If the lab you choose is not participating with your insurance, the lab will bill you and you will be responsible for payment.

I have read the above and understand I am responsible for knowing the coverage and benefits of my insurance policy as well as choosing a lab that my insurance company participates with.

_____
Patient's Signature

_____
Date

HALIFAX OB/GYN ASSOCIATES, LLC
FLORIDA WOMAN CARE, LLC

FINANCIAL POLICY

Thank you for choosing us as your gynecologist/obstetrician. We are committed to providing you with quality and affordable health care. This is an agreement between Halifax OB/GYN Associates, LLC/Florida Woman Care, LL and the Patient/Debtor named on this form. The word "account" means the account that has been established in your name to which the charges are made and payments are credited. The words "we" and "our" refer to Halifax OB/GYN Associates LLC/Florida Woman Care, LLC. By executing this agreement, you are agreeing to pay for all services that are received. A copy will be provided to you upon your request.

Insurance: We participate in a variety of insurance plans. Please provide us with your most current insurance information at the time of each visit to prevent unnecessary claims denials. If you are insured by a plan we are not participating with, payment in full is expected at the time of each visit. We will gladly provide you with an itemized statement of charges that you can submit to your insurer. If you are unable to provide us with a current insurance card, payment in full is required for services rendered until coverage can be verified.
KNOWING YOUR INSURANCE BENEFITS IS YOUR RESPONSIBILITY, PLEASE CONTACT YOUR INSURANCE PROVIDER WITH ANY QUESTIONS YOU MAY HAVE REGARDING YOUR COVERAGE.

Co-payments, Deductibles and Coinsurance: **ALL** co-payments, deductibles, and coinsurances must be paid at the time of service. This arrangement is part of our contract with our insurance provider. Failure on our part to collect co-payments, deductibles, and coinsurances from patients can be considered fraud. Please help us to comply with the law by paying co-payments, deductibles, and coinsurances each visit. THANK YOU.

Elective and Non-covered services: Please be aware that some and perhaps all of the services you receive may not be covered by your insurance provider. Elective and Non-covered services must be paid for in full at the time of your visit.

Proof of insurance: All patients must complete our Patient Information for PRIOR TO seeing the doctor. We must first obtain a copy of your VALID driver's license or state issued identification card and current valid insurance card so that coverage can be verified. Invalid or expired insurance information will result in the patient being responsible for payment of these services.

Claims Submission: If we are a participating provider with your insurance carrier, we will submit all claims and assist you in any way to assure all charges are paid on your behalf. At times, insurance carriers will request additional information from the patient before processing a claim. Please be aware that failure to supply this information could result in claims denial therefore leaving the patient responsible for payment in full.

Coverage changes: If your insurance changes, please notify us upon your arrival for your appointment to insure proper claims submission. It is your responsibility to confirm with your insurance carrier their laboratory of choice for any testing that may occur. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

Missed Appointments: Our policy is to charge $25.00 for missed appointments not cancelled within 24 hours of your scheduled appointment time. New Patients who miss their first appointment will be subject to a No Show Fee of $40.00. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.

Returned Check Fee: There will be a $30.00 fee for checks written up to $300.00 or a $50.00 fee on checks written for $301.00 or over charged to your account for any returned items.

Divorce & Dependent Children: In case of separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent authorizing the treatment of the dependent child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Non-payment: If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account **IN FULL.** Partial payments will not be accepted unless other arrangements are made with our billing department. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of your balance to an attorney, you agree to pay all fees plus court costs incurred in the collection of the account. In case of suit, you agree that the venue be held in Daytona Beach, Florida.

Transferring of Records: You will need to request, IN WRITING, any transfer of medical records. You understand that you may receive one (1) complimentary copy of your medical file to be transferred to a new physician in the event that you transfer your medical care. Any additional requests will result in a charge of $1.00 per page up to 25 pages and $.25 per page for each additional page. You further understand that medical record requests from other entities, such as attorneys, etc. will all be subject to the same charges. In the event that these entities do not cover the required charges, you understand that the charges will become your responsibility. If you are requesting records to be transferred from another physician or organization, you authorize us to send all relevant information, including payment history.

Forms: Any forms filled out on your behalf will be subjected to a $20 fee per form, payable prior to picking up. We ask that you allow 7 days for processing.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

_____ _____ _____

Signature of Patient or Responsible Party Printed Name Date

HALIFAX OB/GYN ASSOCIATES
GYNECOLOGY AND OBSTETRICS

Thomas G. Stavoy, MD., F.A.C.O.G. * Pamela P. Carbiener, MD., F.A.C.O.G. * Stephen J. Cortez, MD. F.A.C.O.G * Cynthia Baldwin, MD., F.A.C.O.G. *Marjorie Bhogal, MD*Patricia Esquivel, MD* *Laura B. Bell, CNM *

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Thomas G. Stavoy, MD, Pamela P Carbiener, MD, Stephen J. Cortez, MD, Cynthia Baldwin, MD, Marjorie Bhogal, MD, Patricia Esquivel, MD,** and **Laura B. Bell, CNM** to use and disclose protected Health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices for **Thomas G. Stavoy, MD, Pamela P Carbiener, MD, Stephen J. Cortez, MD, Cynthia Baldwin, MD, Marjorie Bhogal, MD, Patricia Esquivel, MD,** and **Laura B. Bell, CNM** provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Thomas G. Stavoy, MD, Pamela P Carbiener, MD, Stephen J. Cortez, MD, Cynthia Baldwin, MD, Marjorie Bhogal, MD, Patricia Esquivel, MD,** and **Laura B. Bell, CNM** reserve the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to *Debbie Marz, Privacy Officer, 1890 LPGA Blvd, Suite 160, Daytona Beach, Florida 32117.*

With this consent, **Thomas G. Stavoy, MD, Pamela P Carbiener, MD, Stephen J. Cortez, MD, Cynthia Baldwin, MD, Marjorie Bhogal, MD, Patricia Esquivel, MD,** and **Laura B. Bell, CNM** may call my home or other alternative location and leave a message on voice main or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, **Thomas G. Stavoy, MD, Pamela P Carbiener, MD, Stephen J. Cortez, MD, Cynthia Baldwin, MD, Marjorie Bhogal, MD, Patricia Esquivel, MD,** and **Laura B. Bell, CNM** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confident."

I have the right to request that, **Thomas G. Stavoy, MD, Pamela P Carbiener, MD, Stephen J. Cortez, MD, Cynthia Baldwin, MD, Marjorie Bhogal, MD, Patricia Esquivel, MD,** and **Laura B. Bell, CNM** restrict how they use or disclose my PHI to carry out TPO. This request must be made in writing to the Privacy Officer. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement. By signing this form, I am consenting to the use and disclosure of my PHI by, **Thomas G. Stavoy, MD, Pamela P Carbiener, MD, Stephen J. Cortez, MD, Cynthia Baldwin, MD, Marjorie Bhogal, MD, Patricia Esquivel, MD,** and **Laura B. Bell, CNM** to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, **Thomas G. Stavoy, MD, Pamela P Carbiener, MD, Stephen J. Cortez, MD, Cynthia Baldwin, MD, Marjorie Bhogal, MD, Patricia Esquivel, MD,** and **Laura B. Bell, CNM** may decline to provide treatment to me.

_____	_____
Signature of Patient or Legal Guardian	Print Name of Patient or Legal Guardian
_____	_____
Witness	Date

HALIFAX OB/GYN ASSOCIATES
GYNECOLOGY AND OBSTETRICS

Thomas G. Stavoy, MD., F.A.C.O.G. * Pamela P. Carbiener, MD., F.A.C.O.G. * Stephen J. Cortez, MD. F.A.C.O.G * Cynthia Baldwin, MD., F.A.C.O.G. *Marjorie Bhogal, MD*Patricia Esquivel, MD* *Laura B. Bell, CNM *

Dear Patient:

Thank you for the confidence you have placed in Halifax OB/GYN. Doctors Thomas Stavoy, Stephen Cortez, Pamela Carbiener, Cynthia Baldwin, Marjorie Bhogal and Patricia Esquivel have arranged to care for each other's patients. It is our goal to offer continuity of care with one physician, however, there are times when that will not be possible.

If this is not a satisfactory arrangement, please let me know and we will discuss the matter.

Sincerely,

Halifax OB/GYN Associates

I have read the above and agree to the arrangement for physician coverage.

_____
Patient's Signature

_____
Date

1890 LPGA Blvd., Suite 160 * DAYTONA BEACH, FL 32117 * (386) 252-4701

HALIFAX OBGYN

We are your center for womens' health

As a courtesy to our Patients and to improve the speed and quality of our testing process, our office uses *ResultsCall* to deliver your confidential Test Results.

Once your results are reviewed, our system will notify you that your tests results are available for retrieval. At that time you do not need to call our office to pick up the results of your tests; simply follow the instructions below to access your test results any time of the day or night.

Retrieving your results via the Internet:

Go to our website at www.halifaxobgyn.com and register for the Patient Portal

To Register:

1. **Click on New User Registration**
2. **Enter your First Name, Last Name, Date of Birth, and Home Phone Number, and proceed as directed.**

To Login:

3. **Enter your 5-13 numeric digit PIN. (This is the number you created while registering for the Patient Portal).**
4. **Enter your eight-digit date of birth, using two digits for the month, two digits for the day, and four digits for the year. (Example: September 4, 1980 would be entered 09/04/1980)**
5. **Enter your 10-digit telephone number, which includes your area code. This should be the same number we used to notify you that your results are ready for retrieval.**
6. **Click the Login button.**

To Access Your Test Results by Phone: YOU MUST ESTABLISH YOUR PIN PRIOR TO CALLING FOR YOUR RESULTS

1. **Dial the *Results Call* toll-free access number : 866-747-7027**
2. **Enter you 5-13 numeric digit PIN (This is number you created while registering for the Patient Portal)**
3. **When prompted for your date of birth, enter two digits for the month and two digits for the day, and four digits for the year. (Example: September 4, 1980 would be entered 09/04/1980)**
4. **When prompted for your phone number, enter the 10 digit telephone number, which includes the area code.**
5. **If you have tried to retrieve your test results before being notified by *Results Call* and the system does not recognize your PIN or other personal identifier numbers, this means your test results are not ready for retrieval. PLEASE try calling a bit later.**

Your Test Results will be available as a message on your Portal Welcome screen, as well as within the Lab Results section of My Profile: Health –Labs/Imaging

We hope you will find this new system helpful. If you encounter any problems with the system, please call our office at 386-252-4701.

Thank you

MEDICAL HISTORY

PLEASE CIRCLE ALL THAT APPLY

Cancer-BRCA Tested
Cancer-Breast
Cancer-Cervical
Cancer-Colon
Cancer-Endometrial
Cancer-Lung
Cancer-Other
Cancer-Ovary
Cancer-Skin
Cancer-Vaginal
Cancer-Vulvar
Cardiac-Heart Arrhythmia
Cardiac-Heart Disease
Cardiac-High Blood Pressure
Cardiac-High Cholesterol
Cardiac-Other
Dermatology-Acne
Dermatology-Eczema/Psoriasis
Dermatology-Other
ENT-Hearing Loss
ENT-Other
Endocrinology-Diabetes/History of Gestational Diabetes
Endocrinology-Elevated Prolactin
Endocrinology-Osteopenia
Endocrinology-Osteoporosis
Endocrinology-Other
Endocrinology-Thyroid Problems
Eyes-Cataracts
Eyes-Glaucoma
Eyes-Other
Eyes-Vision Loss/Macular Degeneration
GI-Colon Polyps
GI-Crohn's/Ulcerative Colitis
GI-Gallbladder Disease
GI-Hemorrhoids
GI-Irritable Bowel Syndrome
GI-Liver Disease/Hepatitis
GI-Other
GI-Reflux/Stomach Ulcers
GI-Vitamin Deficiency
Hematology-Anemia
Hematology-Bleeding Disorder
Hematology-Blood Clotting Disorder/Factor V Leiden
Hematology-Blood Transfusion
Hematology-DVT/Pulmonary Embolism
Hematology-Other
ID-Chicken Pox/Shingles
ID-HIV
ID-MRSA
ID-Other
ID-Rheumatic Fever
ID-Tuberculosis/Positive PPD
Neurology-Headaches/Migraines
Neurology-Memory Loss/Dementia
Neurology-Neuropathy
Neurology-Other
Neurology-Seizures/Epilepsy
Neurology-Stroke/TIA
Ortho-Chronic Back Pain
Ortho-Degenerative Joint Disease
Ortho-Fractures
Ortho-Other
Psych-ADD
Psych-Anxiety Disorder
Psych-Bipolar Disease
Psych-Depression
Psych-Eating Disorder
Psych-Other
Psych-PMS/PMDD
Pulmonary-Asthma
Pulmonary-COPD/Emphysema
Pulmonary-Other
Pulmonary-Seasonal Allergies/Allergic Rhinitis
Pulmonary-Sleep Apnea
Rheumatology-Arthritis
Rheumatology-Autoimmune Disease
Rheumatology-Fibromyalgia/Chronic Pain
Rheumatology-Other
Rheumatology-Restless Leg Syndrome
Urology-Frequent Urinary Tract Infections
Urology-Hematuria (Blood in Urine)
Urology-Interstitial Cystitis
Urology-Kidney Disease
Urology-Kidney Infection
Urology-Kidney Stones
Urology-Other
Urology-Urinary Incontinence
Wt Management-Obesity
Wt Management-Other

PATIENT NAME_____DOB_____

Pt Name_____ DOB_____

MEDICATIONS

DRUG ALLERGIES

Pt Name_____ DOB_____

SURGICAL HISTORY

PROCEDURE	DATE
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

OBSTETRIC HISTORY

TOTAL # PREG. _____

FULL TERM_____PRE-TERM_____MISCARRIAGE_____ABORTION_____

ECTOPIC_____MULTIPLE_____LIVING_____

PATIENT PROVIDER (PRIMARY DOCTOR)

_____

PREFERRED PHARMACY

NAME	LOCATION/PHONE
_____	_____

PT NAME_____DOB_____

SOCIAL HISTORY

SMOKING STATUS- NEVER FORMER CURRENT EVERYDAY CURRENT SOMEDAYS

SMOKER AMOUNT- 1 PPW 2PPW 1/4 PPD 1/2 PPD 1PPD 1 ½ PPD 2 PPD 3+ PPD

 # YRS SMOKING- _____

ALCOHOL INTAKE- NONE OCCASIONAL MODERATE HEAVY

CAFFEINE INTAKE- NONE OCCASIONAL MODERATE HEAVY

EXERCISE LEVEL- OCCASIONAL MODERATE HEAVY

DIET- REGULAR VEGETARIAN VEGAN GLUTEN FREE SPECIFIC CARB CARDIAC

MARITAL STATUS- SINGLE MARRIED DIVORCED WIDOWED DOMESTIC PARTNER

EDUCATION- _____

OCCUPATION- _____

FAMILY HISTORY

RELATION	PROBLEM/CONDITION
MOTHER	_____
FATHER	_____
MATERNAL GRANDMOTHER	_____
MATERNAL GRANDFATHER	_____
PATERNAL GRANDMOTHER	_____
PATERNAL GRANDFATHER	_____
SISTER	_____
BROTHER	_____

GYN HISTORY

HOW OFTEN ARE MENSES? MONTHLY LESS THAN 21 DAYS MORE THAN 35 DAYS IRREGULAR

FLOW- LIGHT MODERATE HEAVY

CRAMPS? YES NO

IF MENOPAUSAL WHAT AGE? _____

SEXUALLY ACTIVE? YES NO

CURRENT BIRTH CONTROL METHOD? _____

TOTAL LIFE TIME PARTNERS? LESS THAN 5 MORE THAN 5

HISTORY OF ANY STDS? NO YES **IF YES, WHICH ONE(S)**_____

HISTORY OF:

ABNORMAL PAP BREAST PROBLEMS ENDOMETRIOSIS FIBROIDS

INFERTILITY OVARIAN PROBLEMS PCOS HPV STRESS INCONTINENCE URGE INCONTINENCE

CIRCUMCISION

Our fee for this service is $300 and must be paid by all obstetrical patients desiring this service by the seventh month of pregnancy. We will provide you with a receipt which you may submit to your insurance company for reimbursement. Upon delivery of a female child, the $300 will be refunded to you. Since this is an elective procedure we will not accept any insurance adjustments on the fee.

If circumcision is not paid prior to delivery, the fee is $350.

Be sure to bring your receipt to your delivery so the physician knows you have prepaid for this procedure.

Thank you.

Halifax OB/GYN Associates

_____
Patient Signature

_____
Date

Rev.03132014

HALIFAX OB/GYN ASSOCIATES

GYNECOLOGY AND OBSTETRICS

Thomas G. Stavoy, MD., F.A.C.O.G. * Pamela P. Carbiener, MD., F.A.C.O.G. * Stephen J. Cortez, MD. F.A.C.O.G * Cynthia Baldwin, MD., F.A.C.O.G. *Marjorie Bhogal, MD*Patricia Esquivel, MD* *Laura B. Bell, CNM *

WORKING DURING PREGNANCY

The great majority of expectant mothers can continue to work until late in pregnancy without any problem. Sometimes, however, the physical changes entailed in pregnancy or the demands of a woman's job can create workplace difficulties. Please let us know if you have any concerns in this regard. We usually are able to suggest simple steps to deal with the fatigue, "morning sickness," or aches and pains that can be particularly challenging while you are at work.

If you have more serious symptoms or concerns about potential workplace hazards to you or your baby, we will evaluate and respond accordingly.

When medically appropriate we will recommend that a pregnant patient be placed on disability leave from her job. Such leave is rarely required, however, and in the absence of a serious condition that would endanger the health of the mother or baby, medical ethics prevent is from making such a recommendation. We will, however, do everything we can to reduce or eliminate pregnancy-related difficulties you may be having at work. This includes contacting your employer, when appropriate, to recommend helpful adjustments or alterations to your duties.

Again, please tell us of any work-related concerns you may have.

Signature _____

Date _____

1890 LPGA Blvd., Suite 160 * DAYTONA BEACH, FL 32117 * (386) 252-4701

HALIFAX OB/GYN ASSOCIATES

Prenatal Questionaire and information Form

(Please fill out in as much detail as possible. It will facilitate our ability to give you optimum care.)

DATE:_____ EMERGENCY CONTACT:_____
NAME:_____RELATIONSHIP:_____
ADDRESS:_____PHONE#:_____
OCCUPATION:_____
LAST GRADE COMPLETED:_____
INSURANCE#:_____MEDICAID#:_____
INSURANCE COMPANY:_____
ADDRESS:_____
HOW MANY TIMES HAVE YOU BEEN PREGNANT?(INCLUDE MISCARRIAGES & TERMINATIONS):_____

DATE OF DELIVERY	HOW FAR ALONG IN PREGNANCY (WEEKS)	LENGTH OF LABOR	BIRTH WEIGHT	TYPE OF DELIVERY	PLACE

Were any of these deliveries complicated, if so, please describe:

_____

_____

_____

PAST MEDICAL HISTORY: Have you ever been diagnosed with:

Diabetes	Yes	No	Rh Sensitization	Yes	No
High Blood Pressure	Yes	No	Asthma	Yes	No
Heart Disease	Yes	No	Drug Allergy	Yes	No
Rheumatic Fever	Yes	No	Gyn (Female) Surgery	Yes	No
Kidney Disease	Yes	No	Operations (list below)	Yes	No
Mental Disease	Yes	No	Anesthesia Problem	Yes	No
Liver Disease/Hep	Yes	No	History Abnormal Pap	Yes	No
Varicosities	Yes	No	Uterine Problems	Yes	No
Thyroid Disease	Yes	No	Infertility	Yes	No
Major Accidents	Yes	No	DES Exposure	Yes	No
Blood Transfusions	Yes	No	Street Drugs	Yes	No
Tobacco Use	Yes	No	Alcohol	Yes	No
Describe amt & length of use			Tuberculosis	Yes	No

Explain any yes answers:_____

_____

_____

_____

INFECTION SCREENING (PAST OR PRESENT)

IV Drug Use	Yes	No
Work in High Risk Field (nursing, etc)	Yes	No
Exposure to Tuberculosos	Yes	No
Infected personally or have partners with:		
Genital Herpes	Yes	No
Chlamydia	Yes	No
Syphillis	Yes	No
Genital Warts	Yes	No

GENETIC SCREEN

Are you over the age of 35?	Yes	No
Haitian or Mediterranean Descent?	Yes	No
Oriental Descent?	Yes	No
Have you or any family member had:		
A neural tube defect?	Yes	No
Down's syndrome?	Yes	No
Are you Jewish?	Yes	No
Family history of Tay Sachs?	Yes	No
Hemophilia?	Yes	No
Cystic Fibrosis?	Yes	No
Huntington's Chorea	Yes	No
Mental Retardation?	Yes	No
If so, was person tested for "Fragile X"	Yes	No
Other genetic or inherited disorder?	Yes	No

Have you had more than 3 abortions? _____
Have you had more than 3 miscarriages? _____
Have you ever used Marijuana, Cocaine or other street drugs? _____
Do you medicate yourself with any herbs or non-traditional medicaines?_____

In this pregnancy, have you had :

Any Bleeding?_____
Any Odor?_____
Any Fever?_____
Headaches?_____
Abdominal Pain?_____
Urinary Complications?_____

First Day of your last Menstrual Period_____

HALIFAX OB/GYN ASSOCIATES
GYNECOLOGY AND OBSTETRICS

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VIDEOTAPING

In order to limit distractions and provide optimal care during the delivery of your baby, it is the policy of Halifax OB/GYN Associates to prohibit videotaping during deliveries.

If you have any questions or concerns, please bring these to our attention.

By signing below, you acknowledge you have been informed of and agree to abide by this policy.

_____

Patient's Signature

_____

Date

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CONSENT FOR VAGINAL DELIVERY OR CESAREAN SECTION

To the Patient: You have the right as a patient to be informed about your condition and the recommended medical, surgical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

I (We) voluntarily request Dr._____ as my physician, and such associates, technical assistants, and other health care providers as they deem necessary to treat my condition which has been explained to me as:

PREGNANCY

I (We) understand that the following medical, surgical, or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these PROCEDURES:

VAGINAL DELIVERY OR CESAREAN SECTION

I (We) consent to the disposal by hospital authorities of any tissues, organs, or amputations which may be removed.

I (We) understand that my physician may discover other or different conditions which require different or additional procedures than those planned. I (We) authorize the physician and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (We) _____ do _____ do not consent to the use of blood or blood products as deemed necessary.

I (We) understand that treatment of my medical condition may require transfusions of blood, blood components or derivatives, and I (we) voluntarily consent and authorize such transfusions. It is my (our) understanding that this consent to transfusion applies to this operation and this hospital stay only.

I (We) understand that there are risks and hazards to transfusion, however unlikely, including, but not limited to the following:

1. Allergic reactions, including hives and itching;
2. Fever, sometimes accompanied by chills;
3. Heart failure;
4. Infection by bacteria, parasites or viruses, including malaria, hepatitis and AIDS;
5. The possibility of blood incompatibility, which can result in severe complications, including kidney failure and, rarely, death.

Consent for Vaginal Delivery or Cesarean Section

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I (We) have been given an opportunity to ask questions, and my physician has explained possible alternative forms of treatment, the risk of refusing transfusions, the procedures to be used, and the hazards involved.

I (We) understand that no warranty or guarantee has been given to me as to result.

Just as there are risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures planned for me. I (We) realize that common to surgical, medical, or diagnostic procedures is the potential for infection, blood clots in veins or legs and lungs, hemorrhage, allergic reactions, nerve damage causing numbness and/or pain to lower extremities, and even death.

I (We) also realize that the following risks and hazards may occur in connection with this particular procedure:

IF VAGINAL DELIVERY:

1. Injury to bladder and/or rectum, including a hole (fistula) between bladder and vagina and/or rectum and vagina.
2. Hemorrhage possibly requiring blood administration and/or hysterectomy and/or artery ligation to control.
3. Sterility.
4. Brain damage; injury or even death occurring to the fetus before or during labor and/or vaginal delivery whether or not the cause is known.
5. Risks of anesthesia.
6. Extension of incision or laceration of vagina, cervix, uterus or rectum.

IF CESAREAN SECTION:

1. Injury to bowel or bladder, including a hole (fistula) between bladder and vagina.
2. Injury to tube (ureter) between kidney and bladder.
3. Brain damage; injury or even death occurring to the fetus before or during labor and/or cesarean section whether or not the cause is known.
4. Uterine disease requiring hysterectomy.
5. Sterility.
6. Hemorrhage possibly requiring blood administration, hysterectomy, and/or artery ligation to control.
7. Risks of anesthesia.
8. Extension of incision or laceration of uterus, cervix, or vagina.

I (We) understand that anesthesia involves additional risks, but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures.

I (We) realize the anesthesia may have to be changed without explanation to me (us).

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I (We) understand that certain complications may result from the use of any anesthetic, including respiratory problems, paralysis, drug reaction and even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury of vocal cords, teeth or eyes. I (We) understand that other risks or hazards resulting from spinal or epidural anesthetics include headaches and chronic pain.

I (We) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatments, risks of non-treatment, the procedures to be used, and the risks and hazards involved. This includes the understanding that all DNR (Do Not Resuscitate) orders or advanced directives are suspended while in the operating suite unless special circumstances are discussed prior to surgery on an individual case basis by the surgeon, anesthesiologist and patient or legal next of kin. I (We) believe that I (we) have sufficient information to give this informed consent.

In compliance with the Safe Medical Device Act of 1990, if an FDA designated medical device is implanted during surgery, I understand that my Social Security Number and name will be released to the manufacturer.

I (We) certify that this form has been fully explained to me that I (we) have read it or have had it read to me; that the blank spaces have been filled in, and that I (we) understand its contents.

I authorize the staff of Halifax Health Medical Center to take still photographs, motion pictures, television transmissions, and/or videotaped recordings, provided my identify is not revealed by the pictures or by descriptive text accompanying them.

Date_____Time_____

_____

Signature of Patient

_____

Witness

_____

Signature of Physician Obtaining Consent

_____

Interpreter (if applicable)