

PAUL J. LEICHTER, M.D., P.A., F.A.C.O.G

ANN ANDREWS, A.R.N.P

Diplomate American Board Obstetrics and Gynecology
BEE RIDGE OBSTETRICS & GYNECOLOGY
3920 BEE RIDGE ROAD, BUILDING B , SUITE B
SARASOTA, FLORIDA 34233 (941)921-5302

Today's Date:

Name	Marital Status S M W D SEP	Date of Birth	Age
Street Address		Phone (H) :	
City, State, Zip		Cell:	
S.S#		Driver's License #:	
Employer:		Work #:	
Email Address:			
Emergency Contact (other than spouse)		Phone:	
Personal Physician		Phone:	
Spouse's Name		Date of Birth:	
Spouse's Employer		Phone:	
If under 18 parent/guardian's name		Relationship:	
Address		Phone:	
Referred By:			
PAYMENT IS DUE AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE			
INSURANCE/BILLING INFORMATION			
Insurance Company			
Name of Insured		Relationship	
S.S# of Insured		Date of birth of Insured	
IF YOU WOULD LIKE US TO BILL YOUR INS. COMPANY YOU MUST PRESENT YOUR CARD AT EACH VISIT			

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. Leichter, for services rendered by him or any person under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

LIFETIME AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Dr. Leichter to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefits.

MEDICARE / MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of unauthorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original

Patient Signature _____ **Date:** _____

Parent/Guardian _____ **Signature** _____

PATIENT QUESTIONNAIRE

REASON FOR VISIT:

PAST MEDICAL & FAMILY HISTORY (please check if you or any relative have had the following conditions)

	You/Family		You/Family		You/Family
1. Wt. loss/ Gain		10. Bow el Disorders		19. Night Sw eats	
2. Headaches/Migraine		11. Kidney Disease		20. Thyroid Disease	
3. Heart Disease		12. Urinary Incontience		21. Cancer	
4. Hypertension		13. Urinary Infections		(type)	
5. Respiratory Disease		14. Blood Transfusions		22. Epilepsy/Neuro Disease	
6. Breast Disease		15. Anemia/Blood Disorder		23. Arthritis	
7. Jaundice/Hepatitis		16. Varicose Veins/Phlebitis		24. HIV or AIDS	
8. Gall Bladder Disease		17. Skin Disease		25. Herpres	
9. H. Hernia/Peptic Ulcer		18. Diabetes		26. Other	

MEDICATIONS (List all medication you are currently taking with dosage & frequency) - include OTC drugs

1.	2.	3.
4.	5.	6.

Are you allergic to any medications? Yes No If so which Medications:

HOSPITAL ADMISSIONS/SURGERIES (List operations and serious illnesses which required hospitalization)

Year	Reason for Admission
Year	Reason for Admission
Year	Reason for Admission

MENSTRUAL HISTORY

Age at first menstrual period?	Date of last menstrual period? (1st day)
Period Interval (1st day to 1st day)	#days Duration of bleeding
Cramps : Yes No Mild Mod Severe Always Present Yes No	
Cramps Start Before During or After Bleeding (please circle one)	
Do you take any medication for cramps?	Which Medications?
How many periods did you have last year?	Do you have bleeding or spotting between periods?

VAGINAL INFECTIONS (please circle any of the following vaginal infections you have ever had)

Yeast Trichomonas Chlamydia Herpes Gonorrhea any other infection
Have you ever had HPV, Condyloma, or Veneral Warts Yes No If so when?
Have you ever has an abnormal PAP smear? Yes No If so when?

PAP TEST : Date of last Pap Normal / Abnormal (please circle one)

MAMMOGRAM : Date of Last Mammo Normal/Abnormal (please circle one)

CONTRACEPTIVE HISTORY

Current Method?	If pill - what brand?	Past Methods?
-----------------	-----------------------	---------------

OBSTETRICAL HISTORY - (please indicate the number of times for the following)

Number of times pregnant?	Number of premature births?	Number of miscarriages?
Number of Abortions?	How many living children do you have?	
Month and Year Born	How many weeks pregnant?	Weight? Sex?
Type of delivery?	Location?	Any Complications?
Month and Year Born	How many weeks pregnant?	Weight? Sex?
Type of delivery?	Location?	Any Complications?
Month and Year Born	How many weeks pregnant?	Weight? Sex?
Type of delivery?	Location?	Any Complications?
Month and Year Born	How many weeks pregnant?	Weight? Sex?
Type of delivery?	Location?	Any Complications?

MENOPAUSAL HISTORY (if applicable)

Do you experience hot flashes/sweats yes or no What treatment do you use?

SEXUAL HISTORY do you wish to discuss?

SOCIAL HISTORY (Do you do or use any of the following)

Smoking:	Cigarettes per day:	For how many years?
Alcohol:	Ounces per week:	Coffee: Cups per day:
Street Drugs:	Which Ones:	

BEE RIDGE OBSTETRICS AND GYNECOLOGY
Paul J. Leichter, MD, PA, FACOG
Ann Andrews, ARNP

CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Bee Ridge Obstetrics and Gynecology.

Do we have your permission to: (please circle one)

Call you at home? Yes No

If yes, can we leave the following information on your home answering machine or voicemail?

Appointment Information Yes No

Billing Information Yes No

Medical Information Yes No

Can we call you at work? Yes No

If yes, can we leave the following information on your work answering machine or voicemail?

Appointment Information Yes No

Billing Information Yes No

Medical Information Yes No

I give my permission to share the above information with the person(s) named below:

Name: _____ Relationship _____

Appointment Yes No Billing Information Yes No Medical Yes No

Name: _____ Relationship _____

Appointment Yes No Billing Information Yes No Medical Yes No

Name: _____ Relationship _____

Appointment Yes No Billing Information Yes No Medical Yes No

Name: _____ Relationship _____

Appointment Yes No Billing Information Yes No Medical Yes No

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____