



1617 S. Tuttle Avenue Suite 1A Sarasota, FL 34239
P: 941-330-8885 F: 941-906-8774

PATIENT REGISTRATION

Date: _____

Patient Name: _____ Marital Status: S M D W

Birthdate: _____ SS#: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

EMPLOYER INFORMATION

Employer: _____ Employer Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

SPOUSE INFORMATION

Name: _____ Birthdate: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip: _____ Employer Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Secondary Insurance Co. _____

Policyholder: _____ DOB: _____ Policyholder: _____ DOB: _____

ID#: _____ ID#: _____

Group #: _____ Group #: _____

I understand that my primary insurance will be filed, and if no payment is made within 45 days, I will be responsible for the balance.

Signature: _____

I hereby authorize Swor Women's Care as a holder of medical information, to release to my insurance carrier or it's intermediaries any information needed for this or future related claim(s). I further request payment be made to Swor Women's Care and authorize Swor Women's Care to submit claims on my behalf for any bills or services furnished to me during the next 12 month period (year). I hereby acknowledge and understand that I am financially responsible for any portion of my bill not covered by my insurance carrier. If this account is placed in the hands of a collector or an attorney for collection, reasonable cost of collection including attorney fees will be paid by the undersigned.

Signature: _____ Date: _____



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change it's notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or other health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (please print) _____

Patient Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____

Initials _____

Reason _____



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FINANCIAL POLICY

Here at Swor Women's Care we are dedicated to making sure you receive the highest quality care possible, including making sure you completely understand our financial policies.

1. Unless otherwise advised, payment is due at the time of service. If the co-pay is not listed on your insurance card, it is your responsibility to find out the proper co-payment amount. For your convenience we accept Visa, MasterCard, and Discover.
2. Please remember that your insurance policy is a contract with you and your insurance company. If we are a participating provider with your insurance company we will file your insurance claim as a service to you. Please be advised, if we do not receive payment from your insurance company within a reasonable amount of time we will look to you for payment. If we receive payment from your insurance company after you have paid the balance we will reimburse you.
3. If you participate with an insurance plan that we are not providers of, payment is due at time of service and you will have to submit a claim to your insurance company for reimbursement.
4. Please understand although you may have insurance, all services may not be covered under your insurance plan. If any of the services performed come back "not covered" you will be responsible for the total charge. In the event you accrue a balance in our office we will send you a statement and payment is due upon receipt.
5. Our office does not file to secondary insurance. If you have Medicare as your primary insurance and your secondary does not automatically crossover, then it is your responsibility to pay any balance not paid by your secondary. You may then file to your secondary insurance for reimbursement.
6. If at any time Dr. Swor needs to perform an outpatient surgery on you, we will verify your benefits and submit the claim to your insurance company. Any balance accrued from surgery is the patient's responsibility and is due upon receipt of a statement.
7. If your insurance requires authorization for office visits it is your responsibility to obtain this from your primary care physician. All appointments requiring authorization will be rescheduled if an authorization is not on file.
8. Please verify with your insurance company, your coverage, before having any lab or diagnostic testing performed. If your insurance does not cover screening lab tests, we do offer certain blood tests at a reduced cost to you if performed in our office on a cash pay basis.
9. There will be a \$25.00 charge if you cancel an appointment less than 24 hours in advance. Also, if you "no show" for an appointment you will accrue a \$25.00 charge.

I have read and understand Swor Women's Care's financial policy and agree to abide by its terms. I also understand that at any time our financial policy may be amended.

Signature _____

Date _____

Print Name _____

NAME: _____ AGE: _____ BIRTH DATE: _____ DATE: _____

MARITAL STATUS: S M D W RACE: Caucasian Asian African-American Native-American
Hispanic Other

Family doctor/Internist: _____ Other doctors/specialists: _____

Please describe reason for appointment (chief complaint): _____

Please list all prescription medications and supplements (please indicate strength and dosage): _____

Please list ALL medication allergies: _____

Latex allergy? YES NO Iodine allergy? YES NO

MENSTRUAL PERIOD HISTORY

Check if no longer having menstrual cycles due to menopause or hysterectomy

* If you checked above do not proceed to questions below*
Date of last menstrual period? _____
Age when periods started? _____
How many days apart are your periods? _____
How long do your periods last? _____
Describe your periods: _____

GYNCOLOGIC HISTORY Check if none

N = Normal A = Abnormal

Date of last pap smear (mm/yy) _____ N or A
Date of last mammogram (mm/yy) _____ N or A
Date of last bone density (mm/yy) _____ N or A
Date of last colonoscopy (mm/yy) _____ N or A

PREGNANCY HISTORY Check if not applicable

of times you have been pregnant _____
of live born children _____
of miscarriages/abortions _____
of tubal pregnancies _____

METHOD OF BIRTH CONTROL (circle one) Check if none

Tubal Ligation Vasectomy IUD Diaphragm Foam/Gel
Condoms Depo Provera Norplant Natural Family Planning
Pills/Patch/Ring _____ Other _____

PAST SURGICAL/BIOPSY HISTORY: (Please list type of procedure and year performed)

ILLNESS HISTORY (Other than surgical procedures):

FAMILY HISTORY OF: (Please circle "YES" or "NO". If "YES" please indicate MATERNAL or PATERNAL and which family member)

Ovarian Cancer	YES	NO	_____
Breast Cancer	YES	NO	_____
Uterine Cancer	YES	NO	_____
Cervical Cancer	YES	NO	_____
Colon Cancer	YES	NO	_____
Other Cancer	YES	NO	_____
Heart Attack	YES	NO	_____
Elevated Blood Pressure	YES	NO	_____
Stroke	YES	NO	_____
Osteoporosis	YES	NO	_____
Diabetes	YES	NO	_____
Alzheimer's	YES	NO	_____

FAMILY HISTORY:

		<u>CAUSE OF DEATH</u>	<u>AGE</u>
Mother	Living/Deceased	_____	_____
Father	Living/Deceased	_____	_____
Siblings (Brothers or Sisters)	# Living ____ / # Deceased ____	_____	_____

REVIEW OF YOUR BODY SYSTEMS: Do you have now or have you ever had any of the following? Check "YES" or "NO" is "YES" please explain.

Arthritis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Digestive/Bowel Disorders	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Breast Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Gall Bladder	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Endometriosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Hernia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Headache/Migraine	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Heart Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Elevated Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Anxiety	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Hepatitis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Depression	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Infertility	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Seizure Disorder	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Skin Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Uterine Fibroids	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Urinary Infections	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Abnormal Bleeding	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Ovarian Cysts	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Thyroid Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Pelvic Pain/Abdominal Pain	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
PMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Urinary Leakage/Frequency	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Vaginal Discharge/Odor	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Vaginal Dryness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Bleeding or Pain with Intercourse	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Vaginal Itching or Burning	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Decreased Sexual Desire	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Sleeping Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

SEXUAL HISTORY: Please check if you have NEVER been sexually active

Are you currently sexually active? **YES NO**
 Last time you had sexual intercourse ____ (days/wks/mos/yrs) ago
 Are you in a monogamous relationship? **YES NO**
 If "YES", time with current partner ____ months ____ years
 Have you had more than one sexual partner in the past 12 months? **YES NO**
 Are you attempting/allowing pregnancy? **YES NO**
 Do you have any history of sexually-related infections? **YES NO**

If you circled "YES" to the above question, please check any that apply:
 Genital Herpes (HSV) Genital Warts (HPV) Chlamydia
 Gonorrhea Hepatitis B or C Syphilis
 Trich

Within the past year have you been hit, slapped, kicked or otherwise physically hurt by someone? **YES NO MAYBE**
 Are you in a relationship with a person who threatens or physically hurts you? **YES NO MAYBE**
 Has anyone forced you to have sexual activities that made you feel uncomfortable? **YES NO MAYBE**

OTHER HEALTH CONCERNS YOU WISH TO DISCUSS: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PERSONAL HABITS: (Please circle)

Cigarettes: **YES NO PAST**
 If "YES" or "PAST" # of yrs ____ # per day ____
 Alcohol: **YES NO PAST**
 # of drinks per day? ____
 If not daily, how often? ____

Recreational drug use? **YES NO PAST**
 Exercise: Minutes per day ____ Days per week ____
 List exercise activities: _____

Do you wear your seatbelt? **YES NO**