WOMENS CARE
OF BRADENTON

A. (JOTHI) JOTHIVIJAYARANI, M.D., FACOG

4216 Cortez Road W, Bradenton, FL 34210

Ph: 941-500-3100 | Fax: 941-500-3113 | www.womenscareofbradenton.com

PATIENT INFORMATION FORM

Last Name: _____First Name: _____MI: ___Status: SIN MAR WID DIV

Address: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

DOB: _____Age:_____ Social Security #: _____

Email Address: _____

How Did You Find Out About Us? ☐ Friend/Family ☐ Co-Worker ☐ Internet Search ☐ Event ☐ Facebook

☐ Advertising ☐ Insurance Website ☐ Doctor ☐ Patient Pop ☐ Other _____

Your Preferred Language: English/Spanish/Other _____

Your Ethnicity: Hispanic or Latino/Not Hispanic or Latino/Unknown/Decline

Your Race: American Indian or Alaska Native/Black or African American/Native Hawaiian or Other: Pacific Islander/ White/Asian/Other Race/Prefer Not To Say

Emergency Contact Name: _____Phone number: _____

Relationship to Patient: _____

Primary Insurance: _____

Primary Insured Name: _____ Primary Insured DOB: _____

Relationship to Patient: _____ID #: _____

Secondary Insurance: _____

Preferred Pharmacy: _____

Your Primary Care Physician: _____

CONSENT TO TREATMENT

I request those physicians and other healthcare professionals who care for me to perform or order routine laboratory/diagnostic procedures and therapeutic treatments, which in the judgment of my physician, allows them to document the course of my injury or illness and to provide appropriate medical care. I also understand that it is the policy of Womens Care of Bradenton to perform routine urine testing if needed and urine pregnancy testing on every patient of child-bearing age unless they have had a complete hysterectomy. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the treatments or examinations.

Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ **DOB:** _____ **SSN:** _____

I hereby authorize Womens Care of Bradenton to use and disclose a copy of my health and medical information as described below.

☐ SEND MY RECORDS TO: ☐ OBTAIN MY RECORDS FROM:

Doctor's Name: _____ Doctor's **FAX**: _____

Doctor's address: _____

Purpose: ☐ Continued Medical Care ☐ New Patient ☐ Transfer Care ☐ Personal Use

Type of Information:

- PAPS, MAMMOS, BONE SCANS + U/S ONLY
- Drug abuse, alcoholism, alcohol abuse, venereal disease, abortion or mental health treatment
- HIV testing and/or AIDS diagnosis.
- OTHER _____

I understand that I may revoke this consent at any time by submitting such a request in writing, except where information has already been released. This authorization is valid for sixty (60) days from the date it is signed.

Womens Care of Bradenton reserves the right to charge a fee for copying medical records. There will be a fee of $1 per page for the first 15 pages then $0.25 per page thereafter. Please allow a minimum of 48 hours' notice for copying of medical records.

Patient Signature: _____ Date: _____

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PATIENT MEDICAL HISTORY

Patient Name: _____ **Date of Birth**: _____

Married/Single/Divorced/Widowed (please circle one) **Occupation:** _____

Primary Care Doctor: _____ **Referred By:** _____

Gynecological

Last Monthly Period: _____ Sexually Active: _____ Partners are: Men Women Both

Current method of contraception: _____ Do you perform regular self-breast examinations? Yes No

Pregnancy Detail – Please List All Pregnancy Details (If Any) REGARDLESS OF YOUR AGE

Pregnancies: _____ Miscarriages: _____ Abortions: _____

Child	Birth Date	Birth Weight	Baby's Sex	Weeks of Gestation	Type of Delivery	Notes
1						
2						
3						
4						

Complications During Pregnancy: Diabetes / Hypertension / High Blood Pressure / Pre-eclampsia / Toxemia / Depression / Other: _____

Check all that apply. Include date of last testing.

☐ Pap smear_____ ☐ DEXA Bone Density Scan_____ ☐ Mammo_____ ☐ Colonoscopy_____

Have any of the above been abnormal? YES NO
Which of the above were abnormal? _____

Allergies + Reactions: _____
Pharmacy: _____

SOCIAL HISTORY:

	Current Use	Prior Use	Amount Daily	# Years
Tobacco				
Alcohol				
Drugs				

Current Meds:

_____
_____
_____
_____
_____

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Patient Name: _____ **Date of Birth**: ____/____/____

Surgical History

	Surgery	Year	Comments
1			
2			
3			
4			

Medical History (Please check applicable boxes below.)

		SELF	FAMILY MEMBER (Who?)			SELF	FAMILY MEMBER (Who?)
1	Adopted			27	HIV/AIDS		
2	Allergies			28	Hypertension		
3	Alcohol or drug problems			29	Infectious disease/immunizations		
4	Alzheimer's disease			30	Infertility		
5	Anxiety			31	Inheritable diseases		
6	Asthma			32	Lupus		
7	Autoimmune/lymphatic/hematologic			33	Menopausal		
8	Bleeding/bruising			34	Mental illness		
9	Birth Defects			35	Musculoskeletal		
10	Breast			36	Neurological		
11	Cancer (use NOTE space below)			37	Osteoarthritis		
12	Cardiovascular			38	Osteoporosis		
13	Depression			39	Polycystic Ovaries		
14	Diabetes			40	Psychological		
15	Drug allergies			41	Respiratory		
16	Early menopause			42	Rheumatoid arthritis		
17	Endocrine			43	Sickle cell disease		
18	Endometriosis			44	Skin diseases		
19	Gastrointestinal			45	Smoking		
20	Genetic history and screening			46	Stroke		
21	Gynecological			47	Tay-Sachs disease		
22	Heart attack/disease			48	Thalassemia		
23	Hepatitis			49	Tuberculosis		
24	High cholesterol			50	Urinary		
25	Hip fracture			51	Venous thrombosis		
26	History of problems with anesthesia						

Notes: _____

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Lifetime Notice of Acknowledgement

Patient Name: _____ **Date of Birth**: _____/_____/_____

Appointment confirmation via Phone or SMS:	Yes_____ No_____
Billing information:	Yes_____ No_____
Medical information/results:	Yes_____ No_____
Send yearly appointment reminders via Phone or SMS:	Yes_____ No_____
Test results:	Yes_____ No_____
Permission to access external medication records:	Yes_____ No_____
Permission to access patient portals:	Yes_____ No_____

Consent for my information released to:

Name: _____

Phone: _____Relationship_____

HIPAA ACKNOWLEDGMENT

1) I understand that I may revoke this authorization at any time by notifying Womens Care of Bradenton in writing.
2) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits.
3) I may inspect or copy any information used or disclosed under this agreement.
4) I understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.
5) I hereby acknowledge receipt of the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

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Office Policies and Procedures

Appointment policy-

New patient appointments need to arrive 30 mins prior to their scheduled appointment. Established patients need to arrive 15 mins prior to their scheduled appointment. You will need to bring photo id and insurance card to each appointment.

Cancellation policy-

We request the 24 hours' notice if you are unable to keep your scheduled appointment.

Payment policy-

All payments are due at the time of service. This includes Co-pays, Deductibles and Co-Insurance. We accept cash, check, Visa, Master Card, American Express and Discover. If you are unable to meet your financial obligations you will need to speak with the Billing Manager or Office Manager.

Financial policy-

Womens Care of Bradenton, LLC participates with most insurance carriers. It is the patient's responsibility to verify that our providers are in your insurance plan's network. It is also the patient's responsibility to know their insurance plan coverage and deductibles. We will file your claims as a courtesy to all insurance plans that we participate with but any remaining balance that is patient stated is due either at your next visit or statement in the mail. Any balance not paid within 120 days is subject to collections. Any and all fees associated with sending an account to collections is the patient's responsibility.

Phone calls-

All calls are answered during office hours only. Messages left during business hours will be returned by the end of the day. Messages left after hours will be returned the next business day. If you are having an emergency please call 911 or go directly to the ER.

Prescription refills-

Prescriptions will be refilled if there has been an appointment within the last year. Otherwise, only a 1-month supply will be given and an appointment must be made prior to any additional refills.

Hospital visits-

Our physicians maintain privileges at Blake Hospital, Manatee Memorial Hospital, Doctors Hospital of Sarasota, and Sarasota Memorial Hospital. We deliver only at Sarasota Memorial Hospital. If admitted, and in need of OB or GYN services our on-call physician will see you.

Test Results Policy-

We encourage our patients to register in our patient portal by providing your email. All reviewed results will be posted in patient portal. If you have any type of testing ordered by our office, please allow 3 weeks for the results, if not, please call the office to get the results.

Patient Signature: _____ Date:_____