

CONSENT FOR PELVIC EXAMINATION

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation. For purposes of this consent, vaginal sonography is included.

By signing this consent, I _____ authorize and direct
[Print Patient's Name]

_____ Lisa R. Hearing MD _____

And any treating health care provider, the employed and/or contracted medical personnel of _____ Lisa R. Hearing MD _____ as deemed necessary by my treating physician and the medical students and/or students receiving training as a health care provider who may be involved in my care to perform a pelvic examination may be needed while receiving medical care from _____ Lisa R. Hearing MD _____ in the future, and I hereby agree and acknowledge that this written consent applies to any and all pelvic examinations conducted today, or in the future, by a health care provider, medical student, or student receiving training as a health care provider employed by and/or contracted with _____ Lisa R. Hearing MD _____.

Unless I revoke this consent in writing by hand delivering a copy of the revocation to _____ Lisa R. Hearing MD, PA _____. By my signature below I acknowledge that I have read or have read to me and understand the contents of this form.

Patient/Legal Representative Signature Printed Name and Date

Witness Signature Printed Name and Date

Provider Signature Printed Name and Date

Lisa R Hearing, MD, PA
Obstetrics Gynecology

CONFIDENTIAL COMMUNICATIONS

By signing below you give our practice permission to communicate test results by leaving a message on your voice mail, answering machine, cell phone, home phone.

SIGNATURE

DATE

WITNESS

Lisa R Hearing, MD, FACOg
3893 Military Trail, Suite 1
Jupiter, FL 33458

“Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.”

Patient/Responsible Party

Date

Lisa R. Hearing M.D., P.A.
Obstetrics and Gynecology
 Information Sheet

LAST NAME	FIRST	MIDDLE	PREFER TO BE CALLED
SOCIAL SECURITY #	BRITHDATE	DRIVERS LICENSE #	
STREET ADDRESS		CITY	STATE
		ZIP CODE	
HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER	MARITAL STATUS
EMAIL ADDRESS		RACE / ETHNICITY	
REFERRING PHYSICIAN		REFERRED BY	PRIMARY LANGUAGE
SPOUSE OR EMERGENCY CONTACT	NAME	RELATION	PHONE NUMBER
PHARMACY NAME		PHARMACY PHONE NUMBER	
EMPLOYER		OCCUPATION	
EMPLOYER ADDRESS		EMPLOYER PHONE NUMBER	
INSURANCE		PT RELATION TO INSURED	
POLICY HOLDER NAME		ID NUMBER / GROUP	
HOLDER'S DATE OF BIRTH		PLAN TYPE (PPO, POS, HMO)	
GUARANTOR (RESPONSIBLE FOR BILL):		SELF / SPOUSE/ PARENT	
GUARANTOR NAME		GUARANTOR ADDRESS	
GUARANTOR DATE OF BIRTH		CELL NUMBER	
		GUARANTOR EMPLOYER	

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION: I hereby assign all medical and/or surgical benefits including Medicare, Medicaid, Private Insurance and other health plans to Lisa R. Hearing, M.D., P.A.

I also hereby authorize assignee to release all information, including HIV test results to secure payment. I understand that I am financially responsible for all charges whether or not paid by insurance and will be held responsible for all collection costs and associated legal fees should it become necessary to secure payment for services rendered. I am aware that finance charges will accrue on balances older than 30 days once they have been transferred to the patient's responsibility.

I acknowledge that there will be a \$35 fee for any check returned for insufficient funds, closed account, etc.

A photocopy of this assignment is considered as valid as an original and this assignment and release will remain in effect until revoked by me in writing and delivered to Lisa R. Hearing, M.D., P.A.

SIGNATURE OF PATIENT	DATE	SIGNATURE OF GUARANTOR	DATE
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Lisa R. Hearing M.D., P.A.
Obstetrics and Gynecology
 Medical History

LAST NAME FIRST MIDDLE AGE BIRTHDATE

DRUG ALLERGIES: _____

MEDICATIONS LIST: _____ SURGERIES LIST: _____

CHECK IF YOU HAVE A PERSONAL HISTORY OF:

- | | | |
|--|---|--|
| <input type="checkbox"/> ABNORMAL MAMMOGRAM | <input type="checkbox"/> DIVERTICULOSIS | <input type="checkbox"/> MITRAL VALVE PROLAPSE |
| <input type="checkbox"/> ABUSE - SEXUAL/PHYSICAL | <input type="checkbox"/> DRUG DEPENDENCY | <input type="checkbox"/> NEUROLOGIC PROBLEMS |
| <input type="checkbox"/> ACNE | <input type="checkbox"/> EMOTIONAL PROBLEMS | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> EPILEPSY/SEIZURES | <input type="checkbox"/> LUNG DISEASE |
| <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> EYE PROBLEMS | <input type="checkbox"/> RHEUMATIC/SCARLET FEVER |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> AUTISM |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> GALLBLADDER PROBLEMS | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SICKLE CELL ANEMIA |
| <input type="checkbox"/> DVT or PULMONARY EMBOLISM | <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> ADHD or ADD |
| <input type="checkbox"/> BLOOD TRANSFUSIONS | <input type="checkbox"/> GENETIC DISORDER | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> BREAST DISEASE | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HERNIA | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> DISABILITY |
| <input type="checkbox"/> COLITIS | <input type="checkbox"/> HIV TESTING | <input type="checkbox"/> URINARY INCONTINENCE |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> INTESTINAL PROBLEMS | <input type="checkbox"/> ANXIETY DISORDER |
| <input type="checkbox"/> DIABETES/LOW BLOOD SUGAR | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> OTHER: _____ |
| | <input type="checkbox"/> LIVER DISEASE | |

OBSTETRICAL HISTORY:

TOTAL PREG	FULL TERM	PREMATURE	MISCARRIAGE	ABORTION	ECTOPICS	MULTIPLE BIRTHS	LIVING
PAST PREGNANCIES:							
DATE	SEX	WEIGHT	VAGINAL OR C/S	COMPLICATIONS			

GYNECOLOGIC HISTORY:

ANY INFECTIONS: HERPES CHLAMYDIA GONORRHEA SYPHILIS HPV / WARTS OTHER: _____

ANY ABNORMAL PAPS? _____ TREATMENT: _____ DATE OF LAST PAP: _____

DATE LAST MAMMOGRAM: _____ BONE DENSITY: _____ COLONOSCOPY: _____

PERIODS BEGAN AGE: _____ MENOPAUSE: _____ HORMONE THERAPY: _____

SEXUALLY ACTIVE: YES / NO TYPE OF CONTRACEPTION USED, IF ANY: _____

MENSES OCCUR EVERY _____ DAYS, LAST ABOUT _____ DAYS, WITH HEAVY / MODERATE / LIGHT FLOW

LIST ANY GYNECOLOGIC / MENSTRUAL / SEXUAL PROBLEMS: _____

LIST MEDICAL ILLNESSES IN FAMILY MEMBERS:	PATIENT SOCIAL HISTORY:
PARENTS: GRANDPARENTS:	YOUR HIGHEST LEVEL OF EDUCATION: _____
	YOUR OCCUPATION: _____ RETIRED
SIBLINGS: CHILDREN:	SINGLE / MARRIED / DIVORCED / WIDOWED / IN A RELATIONSHIP
	CIGARETTE SMOKER: FORMER / CURRENT / NEVER
	ALCOHOL USE: YES / NO DAILY / WEEKLY / OCCASIONALLY
	DRUG USE: FORMER / CURRENT / NEVER

YOUR PRIMARY PHYSICIAN'S NAME: _____