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
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
“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 ___________________________
**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.
**Medical History**

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST</th>
<th>MIDDLE</th>
<th>AGE</th>
<th>BIRTHDATE</th>
</tr>
</thead>
</table>

**Drug Allergies:**

**Drugs List:**

**Surgery List:**

**Check if you have a personal history of:**

- [ ] Abnormal Mammogram
- [ ] Abnormal Pap Smear
- [ ] Acne
- [ ] Alcoholism
- [ ] Allergies
- [ ] Asthma
- [ ] Anemia
- [ ] Diverticulosis
- [ ] Mitral Valve Prolapse
- [ ] Acute Problems
- [ ] Drug Dependency
- [ ] Eye Problems
- [ ] Gallbladder Problems
- [ ] Headaches
- [ ] Heart Problems
- [ ] Hepatitis
- [ ] Breast Disease
- [ ] Incontinence
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Anemia
- [ ] Alcoholism
- [ ] Asthma
- [ ] Arthritis
- [ ] Asthma
- [ ] Diabetes/Low Blood Sugar
- [ ] Acne
- [ ] Alcoholism
- [ ] Asthma
- [ ] Arthritis
- [ ] Asthma
- [ ] Mitral Valve Prolapse
- [ ] Diverticulosis
- [ ] Other...

**Obstetrical History:**

<table>
<thead>
<tr>
<th>TOTAL PREG</th>
<th>FULL TERM</th>
<th>PREMATURE</th>
<th>MISCARRIAGE</th>
<th>ABORTION</th>
<th>ECTOPICS</th>
<th>MULTIPLE BIRTHS</th>
<th>LIVING</th>
</tr>
</thead>
</table>

**Past Preganacies:**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SEX</th>
<th>WEIGHT</th>
<th>VAGINAL OR C/S</th>
<th>COMPLICATIONS</th>
</tr>
</thead>
</table>

**Gynecologic History:**

<table>
<thead>
<tr>
<th>ANY INFECTIONS:</th>
<th>HERPES</th>
<th>CHLAMYDIA</th>
<th>GONORRHEA</th>
<th>SYPHILIS</th>
<th>HPV / WARTS</th>
<th>OTHER</th>
</tr>
</thead>
</table>

**Any Abnormal Pap Smear?**

- [ ] Treatment: ____________________________
- [ ] Date of Last Pap: ____________________

**Date Last Mammogram:**

- [ ] Bone Density: ________________________
- [ ] BONE DENSITY: ________________________

**Periods Began Age:**

- [ ] Menopause: _______________________
- [ ] Hormone Therapy: ___________________

**Sexually Active:**

- [ ] 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:**

<table>
<thead>
<tr>
<th>PATIENT SOCIAL HISTORY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents: ____________________________</td>
</tr>
<tr>
<td>Grandparents: ____________________________</td>
</tr>
<tr>
<td>Your highest level of education: ____________________________</td>
</tr>
<tr>
<td>Your occupation: ____________________________</td>
</tr>
<tr>
<td>Retired: ____________________________</td>
</tr>
</tbody>
</table>

**Siblings:**

| Children: ____________________________ |
| Cigarette Smoker: ____________________________ |
| Alcohol Use: ____________________________ |

**Drug Use: ____________________________ |
| Former / Current / Never: ____________________________ |

| YOUR PRIMARY PHYSICIAN'S NAME: ____________________________ |