Raymond Wayne Whitted MD, MPH, L L C
Patient Information

Patient Name:_____ Home Phone:_____
Nombre del Paciente *Telefóno del Hogar*
Home Address:_____ Work Phone:_____
Direccion del Hogar *Telefóno del Trabajo*
City:_____ State:_____ Zip Code:_____ Date of Birth_____
Ciudad *Estado* *Codigo Postal* *Fecha de Nacimento*
Occupation:_____ Social Security:_____
Ocupacion *Numero de Seguro Social*
Employer:_____ Marital Status:_____
Empleo *Estado Civil*
Emergency Contact:_____ Phone Number:_____
Contacto de Emergencia *Telefóno*
Referred By:_____ Driver's License #:_____
Referido Por *Numero de Licencia de conducir*
Allergies/Alergias:_____ E-mail address:_____
** IF YOUR VISIT IS FOR A WELL WOMAN EXAM, CHECK HERE:____ Si su visita es para un examen annual, marque aqui:____

INSURANCE INFORMATION

Name of Primary Insurance: _____
Nombre del Seguro
Address:_____ Phone Number:_____
Direccion *Telefóno*
Group Number:_____ Policy or I.D. Number:_____
Numero de Grupo *Numero de Poliza*
Name of Subscriber:_____ Date of Birth:_____ Relation to Patient: _____
Nombre del Asegurado *Fecha de Nacimeinto* *Relacion al Paciente*
Subscriber's Employer: _____
Empleo del Asegurado
Name of Secondary Insurance: _____
Nombre del Seguro Secundario
Address:_____ Phone Number:_____
Direccion *Telefóno*
Group Number:_____ Policy or I.D. Number:_____
Numero de Grupo *Numero de Poliza*
Name of Subscriber:_____ Date of Birth:_____ Relation to Patient: _____
Nombre del Asegurado *Fecha de Nacimeinto* *Relacion al Paciente*
Subscriber's Employer: _____
Empleo del Asegurado

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept Visa, Master Card. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of your policy. Final payment for all charges is the patient's responsibility and should ib be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos Visa, Master Card. Su seguro medico es un contrato entre usted y compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esda deuda, usted es responsable de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to S.458.320 (5)(g). Florida Law imposed penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida Law.

PHYSICIAN'S RELEASE AND ASSIGNMENT

Thereby authorize payment directly to Raymond Wayne Whitted MD, MPH, LLC. of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by Raymond Wayne Whitted, LLC. I understand that I am financially responsible to Raymond Wayne Whitted MD, MPH, LLC for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a Raymond Wayne Whitted MD, MPH, LLC, todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para processar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.

1. I, the undersigned patient or _____ (name of authorized representative acting on behalf of patient) consent to undergo all necessary tests, medication, treatments, and other procedures in the course of the study, diagnosis, and treatment of my illness (es) by the medical staff and other agents and /or employees of Raymond Wayne Whitted MD, MPH, LLC. The identity of the physician who currently has primary responsibility for my care has been provided to me.
2. I understand that, absent emergency or extraordinary circumstances, non-routine and major medical procedures will not be performed upon me until I have had an opportunity to discuss and agree to them with a physician.
3. 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 diagnosis, examinations or treatments in the hospitals or offices.
4. I hereby authorize the staff of Raymond Wayne Whitted MD, MPH, LLC to take such still photographs, motion pictures, television transmissions, and/or videotaped recording for educational and evidentiary purposes as they may wish.
5. I hereby grant access to medical records for bona fide research to members of the medical staff and other medical researchers and authorize my medical records and results to be used for research. I realize that my records will not be identified as pertaining to me specifically without my expressed permission.
6. I consent to the release of medical information to other institutions, agencies, health care organizations, or health care providers accepting the patient for medical or institutional care, and consent to the release of medical information to the patient's insurer and/or managed care organization and their agents for purposes including but not limited to Utilization Review and Quality Assurance Review.
7. I hereby authorize payment directly to Raymond Wayne Whitted MD, MPH, LLC of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS otherwise payable to me, but not to exceed the Hospital and/or Physician's regular charges for this period of treatment. I agree that a photostatic copy of this authorization is as valid as the original.

I have read and clearly understand the above.

_____ Date:_____ Time:_____ AM/PM
Signature of patient or patient's authorized representative

_____
Witness' Signature

MINOR'S CONSENT: Un-emancipated patients (minors under 18 years of age) must have parents or guardians signature, except for emergency medical care, diagnosis or treatment of a sexually transmitted disease, or treatment of pregnancy.

_____
Parent or Guardian's Signature

EMERGENCY CONSENT: Patient is unattended by legal guardian, health care surrogate, or relative and/or unable to sign consent for treatment necessary to correct or stabilize a serious medical condition (s) demanding immediate medical attention. I certify that this condition will endanger the life, limb or health of the patient and authorize emergency procedures

_____ Date: _____ Time: _____ AM/PM
Physician's Signature

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www.drwhitted.net

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Advanced Colposcopy
Abnormal Periods
Bladder Prolapse
Chronic Pelvic Pain
Endometriosis
Ectopic Pregnancy
Family Planning
Fibroids
Genital Warts
Immunizations
Loss Of Urine
Menopause
- Risk Assessment
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Financial Policy

Thank you for choosing Dr. Raymond Wayne Whitted MD, MPH as your health care provider. He is committed to your successful treatment. Pleas understand that payment of your bill is considered part of your treatment. The following is a statement of his Financial Policy which we require you to read and sign prior to any treatment.

ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT

ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO ANY SURGERY

WE ACCEPT: CASH, CHECK, MAJOR CREDIT CARDS: VISA, MASTERCARD

INSURANCE: We will bill your insurance company for your visit as a courtesy to you. Due to difficulty of obtaining payment from your insurance plans, we may ask for your assistance in getting your claim paid. Please be advised that it is ultimately your responsibility to verify that we are a participating provider of your insurance plan.

HMO/REFERALS: It is your responsibility to obtain a referral from your primary care physician if your insurance carrier requires it for your visits. It is your responsibility to know and understand the requirements of your insurance plan. Our office is not responsible to obtain referrals for patients on HMO plans. If you arrive without a referral for your visit and are required to bring one, you may wait and try to obtain the referral or you may reschedule your appointment.

MINOR PATIENTS: The parent or guardian accompanying the minor patient is responsible for payment of the bill.

RETURNED CHECKS: Any checks returned for any reason will be subject to any bank fees charged to us along with 5% of the face value of the check or $30 administrative fee (whichever is greater).

COLLECTIONS: Should your account become a collection problem, you/debtor assumes all costs of collection including but not limited to collections agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

NON-COVERED SERVICES: You will be responsible for payment of services "not covered" by your insurance plan. It is your responsibility to understand your insurance plan's benefits and/or limitations.

INTRAUTERINE DEVICES/OTHER MEDICAL DEVICES: Often insurances do not cover the costs of these devices. If you choose to use medical devices your insurance company does not con-tract to cover or only contracts to partially cover, you, then, are responsible for the purchase costs of the-ses devices.

I HAVE READ AND FULLY UNDERSTAND the Financial Policy. I hereby agree to render payment in accordance with the terms and conditions set forth.

Signature _____ Date _____ DOB_____

Print Patient Name: _____

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Patient Notice

Date: _____

Dear Valued Patient:

After completion of a test and or diagnostic procedure, if you have not heard from our office in two weeks, it is your responsibility to call for results.

_____

Patient Signature

Fecha: _____

Estimado Paciente:

Despeus de haver completado un examen o un procedimiento e diagnostico, y, hayan pasado dos semanas sin una llamada nuestra, es su responsabilidad llamarnos para saber de sus resultados.

_____

Firma del paciente

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Notice of Privacy Acknowledgement

Notificacion De Privacidad En Las Practicas Medicas

I have read and understood the Notice of Privacy Practices.

(Yo he leido y comprendo la Notificacion de Privacidad en las Practicas Medicas)

Date (Fecha)_____

Patient's Name Printed (Nombre de Patiente) _____

Patient's Signature (Firma de Patiente)_____

Witness _____

8585 Sunset Drive Suite 108 Miami, Florida 33143
Phone 305 596 3744 ● fax 305 596 3676● www.drwhitted.net

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CONSENT FOR RELEASE of Medical Information

I, _____, hereby authorize the release of all my medical records, histo-pathology slides, cytology slides, X-Rays, etc., to be released from

_____

_____

_____

Please forward requested records to the address below:

Raymond Wayne Whitted MD, MPH, FACOG
8585 Sunset Drive
Suite 108
Miami, Florida 33143
Telephone: 305-596-3744
Fax: 305-596-3676

Patient's Signature _____

Date: _____

DOB: _____ Witness: _____
Date: _____

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CONSENT FOR RESULTS RELEASE

Name		DOB	

I hereby give my permission to Dr. Whitted and office staff to release results of any laboratory work, test results, mammogram or other medical results (whenever they are unable to contact me) to any or all of the individuals or devices checked below:

			Please write your numbers/email if we can contact you through them
Husband	yes	no	
Parent	yes	no	
Significant other	yes	no	
Home phone and answering machine	yes	no	
Cell Phone	yes	no	
Contact you at work	yes	no	
email	yes	no	

Name		Date	

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Laboratory Administration Fee

Date: _____

Name:

_____

I Understand I have the option of going to my insurance specified lab for la b work, but hae chosen to have my labs drawn here and pay a convenience/administrative fee of $15.00

_____

Patient Signature

Fecha: _____

Nombre de Paciente:

_____

Yo entiendo que tengo la opcion de ir a el laboratorio, pero he decidido que me hagan los analisis en la oficina, y que pagare el cargo de administracion de $15.00.

_____

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Understanding Surgical Assistance

You are about to have surgery. The American College of Obstetrics and Gynecology writes:

Statement on Surgical Assistants. Committee Opinion 240: August 2000.

"Competent surgical assistants should be available for all major obstetrics and gynecologic operations. In many cases, the complexity of the surgery or the patient's condition will require the assistance of one or more physicians to provide safe, quality care. Often, the complexity of a given surgical procedure cannot be determined prospectively. Procedures including, but not limited to, operative laparoscopy, major abdominal and vaginal surgery, and cesarean delivery may warrant the assistance of another physician to optimize safe surgical care."

"The primary surgeon's judgment and prerogative in determining the number and qualifications of surgical assistants should not be overruled by public or private third-party payers. Surgical assistants should be appropriately compensated."

Most surgical physicians in Miami utilize hospital designated surgical assistants. These are often not specialty trained United States physicians and often do not have experience with your particular surgery.

Because we are minimally invasive gynecologic surgeons and many of our surgeries are very technical, it is important, for your safety, to have qualified assistance at your surgery. Dr. Whitted is a Board-Certified Gynecologist with special certification in minimally invasive gynecologic surgery.

It is our standard practice to charge 30% of the Surgeon's fee as the assistance's fee. Your insurance may not have contracted with you to pay for surgical assistance. If this is the case, it is your responsibility to pay the fee. Remember your safety is our utmost concern.

Signature _____ Date _____ Time_____

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Medical Malpractice Insurance Acknowledgement

Dear Patient,

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 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.

I, _____ have read
(patient's Name—Print)

and understand the above.

_____ Date _____
Patient's Signature

_____ Date _____
If minor, parent/Guardian's Signature

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Health History Questionnaire

The health history questionnaire gives the physicians vital information about your health. It is important to answer questions accurately so that appropriate decisions regarding your healthcare can me made. This questionnaire will become part of your medical record and will be treated confidentially as outlined by the HIPAA guidelines.

The questions asked are those normally asked during the course of an initial examination.

Please take the time you need to finish the questionnaire. Do not worry about questions you cannot answer. If you are not sure how any question should be answered, or if you feel uncomfortable answering any question, place a check mark in the margin, and I will go over them with you.

If any section does not apply to you, please mark it N/A (not applicable).

Your Full Name _____Birth Date_____

Your previous OB/GYN physician was _____

Your Primary Care Physician is _____

As a courtesy to our other patients, please telephone and cancel one day in advance if you are unable to keep this appointment.

Thank you,

Dr. Whitted and Office Staff

Who Referred you to our office?	

Special Problems

Describe nay special problems or symptoms you would like to discuss with the doctor

How long have you had this problem?	
Have you seen a doctor for this problem in the past?	
How was your problem diagnosed?	
What treatment was given?	
Did the treatment help you?	

Menstrual History

At what age did you begin having periods?		**Were they regular or irregular?**	
When was your last menstrual period?		**Was this period normal for you?**	

How many days do you bleed?		**How often do your periods occur?**	**Less than 21 days**		**22-35 days**		**More than 35 days**	
			Very irregular		**Infrequent**		**I have never had one**	

Compared to 6 months ago, my period now is	**Heavier**		**Lighter**		**unchanged**					
Do you have clots during your period?	**Yes**		**Size of clots**	**dime**	**Nickel**	**Quarter**	**50 cent**	**dollar**		
	no									
How many days are heavy days?		**Do you use two protections on your heavy days?**								
How often do you change your protections?	Less than every hour		hourly		Every 2 hours		Every 3 hours		Every 4 hours	
Do you stain your clothes?	**yes**		**no**		**Do you put a towel on the bed at night?**		**yes**		**no**	
Do you change your protection at night?	**Yes**		**No**		**My cramps are**	mild		moderate	**severe**	
Have you ever taken medicine to regulate your period?	**Yes**		**no**		**If yes describe**					
Do you feel like your period controls your life?										

MENSTRUAL FLOW DAYS

Number of pads that are	DAY 1	DAY 2	DAY 3	DAY 4	Day 5	Day 6	Day 7	Day 8
1/3 soaked								
½ soaked								
Completely soaked								
Size of clots								

Number of tampons that are	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7	DAY 8
1/3 soaked								
½ soaked								
Completely								
Size of clots								

CONTRACEPTION HISTORY

What type of contraception are you using now?	None		Birth Control Pills		Name of pill currently using						
	Abstinence		Ortho Evra Patch		Depo Provera Shot		Tubal Ligation				
							Vasectomy				
	Condoms		Nuvaring		Paraguard IUD		Mirena IUD		Lippes loop IUD		

List all contraceptive methods used in the past	
What is the method you are most satisfied with	

Medicines and Allergies

List all medications you are currently taking now	
Please list all medications you have allergies too and what the allergy is	

If You Have…Vaginal Discharges and Feminine Hygiene Issues

If you have abnormal discharge describe it	Smelly/odor		Itchiness		Burning		
	White		Yellow/green		Pink/brown		
	Clumpy/cheesy		Water/runny		Thick		

How long has this been going on		What treatments have you used in the past		Were they successful	

How often do you douche?	Weekly		Monthly		Other		
What type of douche do you use?							
Do you use feminine sprays?	yes		no		If yes than what type do you use?		
What type of bathing soap do you use?							
Do you use scented/dyed toilet tissue?							
Do you take tub baths/bubble baths or sit in jaccuzzis?							

If You Have…Bladder and Urinary Issues

Urgency Incontinence Questions

Do you usually have a strong sense of urgency to urinate?	Yes		No	
Do you have to hurry to empty your bladder when full?	Yes		No	
Do you ever not make it in time and leak urine?	Yes		No	
Can you overcome the sensation of urgency to urinate?	Yes		No	
Does the sight, sound, or feel of running water cause you to lose urine?	Yes		No	
Do you ever lose urine when lying down?	Yes		No	
Do you have a warning before losing urine?	Yes		No	
When urinating, can you usually stop your stream?	Yes		No	
Do you ever accidentally wet the bed while asleep?	Yes		No	

Stress Urinary Incontinence Questions

Do you lose urine while coughing, sneezing, laughing, lifting, jumping, and running?	Yes		No	
Do you find it necessary to use some type of protection secondary for this?	Yes		No	

How often do you urinate during the day?	1-3	4-6	7-10	11-15	16-20
How often do you get up at night to urinate	1	2	3	4	5

Do you practice kegel exercises?	yes		No		If so how many times/day	25	50	75	100	
Have you ever passes a kidney stone?	yes		No		Do you have kidney stones now?	yes		No		

If you feel your bladder has fallen describe your symptoms?	
Does your bladder problems affect your quality of life?	

Please circle the bladder irritants you eat or drink	Caffeine drinks	All citrus	Chocolate	Spicy foods	Alcoholic beverages	Artificial sweeteners

Papanicolau History

When was your last pap smear?		Have you had an abnormal pap?	yes		no		date	
Did you have colposcopy?	yes		No		What was your diagnosis?			
What treatment did you receive for your abnormality?								
What follow-up was recommended?								

Mammogram History and Breast Issues

Do you do monthly self-breast exam?	yes		no		When was your last mammogram?				
Do you have breast discharge?	Yes		no		Describe it	watery		Bloody	
						milky		other	
Have you noticed lumps in your breasts?	Yes		no		Draw the location of any lumps that concern you	Right		Left	
Has your Mammogram always been normal?	Yes		no		Have you ever had a breast biopsy?	Yes		No	
What was the diagnosis of the biopsy?									
What follow-up was recommended?					Who is following you?				
Where did you have the breast biopsy?									
If you have or have had breast cancer when was it diagnosed?		What Type of cancer?			What type of surgery?				
Did you receive Chemotherapy?	yes		No		Radiation therapy?	Yes		No	

If You Have… MENOPAUSE ISSUES

Do you think you are entering or are in the menopause?	Yes		No		At what age do women in your family go through the "change"?	
Circle the menopause symptoms that are bothering you	Hot flushes	Night sweats	Insomnia	Memory loss	Mood issues	Libido issues	Change in vision
	Concentration loss	palpitations	Sense of doom				
List alternative therapies you have tried							

If You Have… Sexually transmitted Disease Issues

Please circle the STD you have had	Chlamydia	Gonorrhea	HPV	Genital Warts
	Syphilis	HIV	Hepatitis B or C	Genital Herpes
What was your treatment?				

Have you ever had an infection in your ovaries or fallopian tubes (PID)?	yes		No		Were you hospitalized?	yes		No	
Do you bleed or spot after sex?	yes		No		Do you have deep pain with sex?	yes		No	

If You Have… Pelvic Pain Issues

	List each pain location	Note the date it was first noticed	Describe the events before the pain	Describe the type of pain	Rate the intensity of the pain (0 to 10)
1					
2					
3					

Interference of pain with life (0 to 10)	Work	School	Social Activities	Childcare	Sports/exercise	Relationships	other

It gets worse		It gets better with		My previous evaluation		My treatment has been	
Sex		Lying down		GI studies		Surgery with dates	
Bowel movements		Heating pad		Bladder/kidney studies			
Urination		Hot bath		Ultrasound		Medicines used	
Activities		Medication		CT scans			
other		other		MRI scans			

What was the diagnosis given for your pelvic pain?		How was it diagnosed?	
What treatments to date have been effective?			

Social Habits

Do you smoke cigarettes?	Yes		No		How many cigarettes/day?	< 1 pack	1 pack	> 1 pack
If you quit smoking, how many years did you smoke?								
How many alcohol drinks do you have in 1 week?					How many caffeinated drinks/day?			
Do you use recreational drugs?	yes		No		If yes, please list them			
How many times/week do you exercise?		Do you take calcium?	Yes		No		Amount?	
Do you take vitamins?	Yes		No		My stress level is (0 to 10)			
I am a victim of Domestic Violence	Yes		No					

Pregnancy Issues

How many times have you been pregnant?		How many live babies have you had?		Miscarriages?	
How many Cesarean sections have you had?		How much did your largest baby weigh?			
Did you have high blood pressure during pregnancy?	yes		No		
Did you have diabetes during pregnancy?	Yes		No		
Did you have blood clots in your legs during pregnancy?	Yes		no		

General Medical History

Please list any medical problems you have with the following organs

Heart		Bowels	
Lungs		Eyes/ears	
Liver		Musculoskeletal	
Kidneys		Brain/nerves	
Stomach		Psychiatric	

Please circle the following conditions if you have them

High Blood Pressure		High cholesterol		Autoimmune disorder		Bleeding disorders		Hypothyroid		Hyperthyroid		migraines	
Diabetes		Kidney stones		Blood clots		Phlebitis		Arthritis		Seizures		anemia	
depression		Other											

My cholesterol is		My last anemia level was	

Past Surgical History (please list all surgeries you have had)

Year	Type of surgery

Family History

Please list your immediate relatives who have had the following conditions

Heart Disease/Stroke	
Osteoporosis	
Breast cancer	
Ovarian Cancer	
Colon Cancer	
Diabetes	
Hypertension	
Psychological disorders	

Please describe any medical history not covered in this questionnaire