DATE_____

PATIENT NAME_____
(FULL NAME, INCLUDING MIDDLE INITIAL)

HOME ADDRESS_____

CITY_____STATE_____ZIP CODE_____

HOME PHONE ( )_____BUSINESS PHONE ( )_____

BIRTH DATE_____AGE_____

MARRIED ( ) SINGLE ( ) WIDOWED ( ) DIVORCED ( ) SEPARATED ( )
SIGNIFICANT OTHER ( ) LIFETIME PARTNER ( )

SS#_____EMPLOYER_____

OCCUPATION_____

BUSINESS ADDRESS_____

CITY_____STATE_____ZIP CODE_____

****

NAME OF SPOUSE_____SPOUSE SS#_____

SPOUSE EMPLOYED BY _____OCCUPATION_____

BUSINESS ADDRESS_____

CITY_____STATE_____ZIP CODE_____

SPOUSE BUSINESS PHONE_____

****

PATIENT REFERRED BY_____

OTHER PHYSICIANS WHO CARE FOR YOU_____

IN CASE OF EMERGENCY, PLEASE CONTACT_____

RELATIONSHIP TO YOU_____PHONE NO._____

****

OMIT THIS SECTION IF WE CAN COPY YOUR INSURANCE CARD

INSURANCE CO. NAME_____

INSURANCE CO. ADDRESS_____

SUBSCRIBER_____

PATIENT'S RELATIONSHIP TO SUBSCRIBER_____

INSURANCE CERTIFICATE NUMBER_____GROUP NO._____

LIFETIME SIGNATURE AUTHORIZATION

PAYMENT AGREEMENT AND MEDICAL RECORDS RELEASE

I understand that I am responsible for full payment of services rendered to me by the practice of Philip F. Waterman II, M.D. I understand that payment is due at the time of service.

I understand that I am responsible for all outstanding balances not covered or paid by my insurance companies. I agree to assume any necessary fees involved with the collection of this account should it become delinquent.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I authorize any holder of medical or other information that is necessary to process this claim to release my records to the billing agents of my insurance company listed above or to my employer if this is a worker's compensation claim.

I permit a copy of this authorization to be used in place of the original.

_____

Patient's Signature Date

_____

Print Patient's Name

_____

Witness

Form1(updated 6/29/2009)

PHILIP F. WATERMAN II, M.D., F.A.C.O.G.
650 DEL PRADO BLVD.
SUITE 100
CAPE CORAL, FLORIDA 33990

MEDICAL HISTORY

DO YOU NOW HAVE OR HAVE YOU EVERY HAD:

	NOW	IN THE PAST		NOW	
ANEMIA:	_____	_____	HEART MURMUR:	_____	_____
ASTHMA:	_____	_____	HEADACHES:	_____	_____
BLADDER INFECTIONS:	_____	_____	HEPATITIS OR JAUNDICE:	_____	_____
BLOOD CLOTS IN LEGS:	_____	_____	HIGH BLOOD PRESSURE:	_____	_____
BLOOD TRANSFUSIONS:	_____	_____	KIDNEY INFECTION:	_____	_____
BRUISING TENDENCY:	_____	_____	MITRAL VALVE PROLAPSE:	_____	_____
CHEST PAIN:	_____	_____	PNEUMONIA:	_____	_____
CONSTIPATION:	_____	_____	RHEUMATIC FEVER:	_____	_____
CONVULSIONS:	_____	_____	SHORTNESS OF BREATH:	_____	_____
DIABETES:	_____	_____	THYROID DISEASE:	_____	_____
DIARRHEA:	_____	_____	TUBERCULOSIS:	_____	_____
EXPOSURE AIDS VIRUS:	_____	_____	OTHER:	_____	_____

LIST ALL OPERATIONS AND HOSPITALIZATIONS: _____

_____

_____

_____

ALLERGIES TO DRUGS: _____

CURRENT MEDICATIONS _____

_____

_____

DO YOU SMOKE: _____ IF SO, HOW MUCH: _____ DO YOU DRINK: _____ IF SO, HOW MUCH _____

USUAL WEIGHT: _____ MAXIMUM WEIGHT: _____ HEIGHT: _____

LAST CHEST X-RAY: _____ LAST MAMMOGRAM: _____ LAST PAP SMEAR: _____

DOES ANYONE IN YOUR FAMILY, PARENTS, GRANDPARENTS, SIBLINGS, AUNTS, UNCLES OR FIRST COUSINS HAVE BREAST, OVARIAN, UTERINE OR COLON CANCER?

_____

_____

PATIENT NAME:_____ DATE:_____

OBSTETRICAL - CONTRACEPTIVE - GYNECOLOGIC HISTORY

OF PREGNANCIES:_____ # OF LIVING CHILDREN:_____ DATE OF LAST PREGNANCY_____

MISCARRIAGES:_____ TERMINATIONS:_____

ANY COMPLICATIONS OF PREGNANCY?_____

PRESENT CONTRACEPTION USED BY YOU OR YOUR PARTNER: (include tubal ligation/vasectomy)

_____

TYPES OF CONTRACEPTION USED IN THE PAST:_____

MENSTRUAL HISTORY:

AGE OF FIRST PERIOD:_____ AGE WHEN PERIODS BECOME REGULAR:_____

HOW LONG DO PERIODS LAST:_____ ANY BLEEDING BETWEEN PERIODS:_____

LENGTH OF TIME FROM START OF ONE PERIOD TO START OF NEXT:_____

ANY PROBLEMS WITH YOUR PERIODS:_____

DATE YOUR LAST PERIOD STARTED:_____

DO YOU NOW HAVE, OR HAVE YOU EVER HAD:

	NOW	IN THE PAST
Abnormal Bleeding		
During Periods:	_____	_____
Between Periods:	_____	_____
After Intercourse:	_____	_____
Abnormal PAP Smear:	_____	_____
Breast Tenderness:	_____	_____
Breast Lumps:	_____	_____
Burning on Urination:	_____	_____
Frequency of Urination:	_____	_____
Genital Warts:	_____	_____
Heavy Pressure in Vagina or Lower Abdomen:	_____	_____
Loss of Urine when Coughing or Sneezing:	_____	_____
Low Abdominal Pain -		
During Periods:	_____	_____
Between Periods:	_____	_____
Pain/Difficulty with Intercourse:	_____	_____
Pelvic Inflammatory Disease	_____	_____
PMS:	_____	_____
Sexually Transmitted Diseases:		
Chlamydia:	_____	_____
Gonorrhea:	_____	_____
Herpes:	_____	_____
HIV:	_____	_____
Syphilis:	_____	_____
Treatment for Bladder Infection:	_____	_____
Treatment for Kidney Infection:	_____	_____
Vaginal Discharge:	_____	_____
Vaginal Irritation:	_____	_____

WHAT IS THE REASON FOR YOUR VISIT TODAY?_____

_____

_____

PATIENT HIPAA AWARENESS

With my permission, Dr. Philip F. Waterman II may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Philip F. Waterman II's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Philip F. Waterman II reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Philip F. Waterman II may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Philip F. Waterman II may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Dr. Philip F. Waterman II may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Philip F. Waterman II restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Philip F. Waterman II to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

PHILIP F. WATERMAN II, M.D.

Gynecology
Infertility & Genetics
Fellow American
College of Obstetrics
and Gynecology

650 Del Prado Blvd.
Suite 100
Cape Coral, Florida 33990
239/574 8200
FAX 239/574 8928

FINANCIAL POLICY - OFFICE OF PHILIP F. WATERMAN II,M.D.

1) I agree that should my account become deliquent, I will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs, collection agency fees and interest at the rate of 18% per annum (1.5% per month).

2) I hereby authorize my current insurance carrier to foward all medical payment(s) on my behalf to Philip F. Waterman II, M.D. for any services furnished to me by the physician of this practice. I further authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This authorization will not be cancelled until further written notice, as this is a lifetime signature of Patient/Guardian. I understand that any amount not covered by my insurance company for ANY reason is my responsibility, and I, being the patient/guarantor, am solely responsible for the payment of any balance on my account.I further understand that if my account should be turned over for collection and/or legal action, I agree to pay for all collection fees including, but not limited to postage, court costs, collection agency fees, attorney's fees, and interest from the date of service in the amount of 18% per annum (1.5% per month).

3) I authorize Philip F. Waterman II, M.D. to submit insurance claims on my behalf. I am aware that this service is being provided as a courtesy. I understand that I will be financially responsible for all services that are not paid in full within 45 days of service regardless of any reason given by the insurance company. If this account should become deliquent and /or past due after 90 days, I agree to pay all costs of collection including, but not limited to , court costs, sheriff fees, collection agency fees, attorney's fees, and interest from the date of service in the amount of 18% per annum (1.5% per month).

_____ Date _____

_____

PLEASE PRINT FULL NAME OF PATIENT/ GUARDIAN