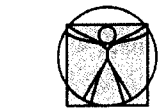
**** PLEASE ARRIVE 30 MINUTES BEFORE YOUR APPOINTMENT TIME**

**** PLEASE BRING ID AND INSURANCE CARD WITH THIS PAPERWORK**



Jacqueline L. Taylor, M.D. ◊ Soyoung Bae, M.D.
Jillian L. Krywko, NP-C ◊ Lacey Waits, NP-C

1435 E 12 Mile Road ◊ Building D ◊ Madison Heights, MI 48071
Crown Office Village ◊ 248-543-2229

Today's Date: Appointment Date:

Patient Information

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___)-____-____ Business Phone: (___)-____-____ Cell Phone: (___)-____-_____

Social Security Number: ____-____-_____ Birth Date: ___/___/____ Age: ____

Married___ Life Partner___ Widowed___ Single___ Divorced___ (please check one)

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Referring Physician: _____ Referring relative or friend: _____

Email Address: _____

Spouse/Guardian Information

Spouses name: _____ Guardians Name (minor): _____

Employer: _____ Work Number: _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: (___)-____-____ Business Phone: (___)-____-____ Car Phone: (___)-____-____

Social Security Number: ____-____-_____ Birth Date: ___/___/____ Age: ____

Medical Information

Primary Care Physician: _____

Primary Care Location: _____

Emergency Contact: _____

Relation to Emergency Contact: _____

Emergency Contact Number: _____

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To all of our patients:

Due to the continuous change of insurance benefits, we are unable to maintain current coverage information on every patient's policy. It is therefore necessary that the subscriber/patient be aware of their benefits, such as:

HOSPITAL PRECERTIFICATION
PRIOR AUTHORIZATIONS
SECOND OPINONS
COST SHARING PROGRAMS (DEDUCTABLE/COPAYS)
LABORATORY COVERAGE

IMPORTANT: REGARDING PROCESSING OF LABORATORY TEST

You must also be aware of what laboratory your tests are sent to. All blood test, cultures, and smears prepared in our office are sent to **Lab Corporation** for reading the cultures, smears, and blood testing. The patient is responsible for all cost incurred by the lab.

These tests are not included in the physician's fee for the exam you receive.

Thank you for your cooperation

_____ _____

Signature **Date**

Jacqueline L. Taylor M.D. ◊ Soyoung Bae, M.D.
Jillian L. Krywko, NP-C ◊ Lacey Waits, NP-C

Dear Patient:

All of our patient's billing is done through a computer system off site. To facilitate our billing process, in terms of the doctor receiving payment, or you being reimbursed, we need a signature on file and a release of medical information.

Please sign below. This form will be kept in your medical chart. Thank you for your cooperation.

1. Signature of patient or authorized person. I authorize the release of any medical information necessary to process billing claims and request benefits either to myself or the party that accepts assignments or participation.

   X_____ Date_____

2. I authorize payment to my physician for services rendered to him/her. I also will be responsible for any co pays and/or deductibles required by my particular insurance company plan. You will also be charged $25.00 for not giving office 24-hour notice of cancellation.

   X_____ Date_____

Consent for Purpose of Treatment, Payment, and Healthcare Operations

I acknowledge that **Davincii OB/GYN** Notice of Privacy Practices prior to signing this document. **Davincii OB/GYN** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performances of health care operations of **Davincii OB/GYN.** The Notice of Privacy Practices also provided on request at the main administration desk of this practice. This Notice of Privacy Practice also describes my rights and **Davincii OB/GYN** duties with respect to my protected health information.

Davincii OB/GYN reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office of **Davincii OB/GYN** and request a revised copy to be sent in the mail or asking for one at the time of my next appointment.

_____ Date:_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative Authority

Jacqueline L. Taylor, M.D. Soyoung Bae, M.D.
Jillian L. Krywko, NP-C Lacey Waits, NP-C

We would like to thank you for taking the time to complete this short questionnaire. We apologize for any inconvenience. Electronic Health Records serve as an important facilitator for collecting patient demographic data. The 2009 economic stimulus bill and 2010 health system reform bills, both strongly encourage collection of this data. Due to recent government initiatives to promote the use of electronic health records and in compliance with Meaningful Use, the reporting of the patient's racial background is now a requirement. Please complete the following information regarding the patient who is being seen today.

**** THIS OFFICE MAY E-PRESCRIBE AND VIEW MY EXTERNAL HISTORY PRESCRIPTIONS: Yes or No (Answer required) ****

Patient Name: _____

Email: _____

Pharmacy Name: _____ City: _____

Pharmacy Phone#: _____ Cross Streets: _____

IF YOU ARE UNCOMFORTABLE ANSWERING THE QUESTIONS, YOU MAY SELECT "I REFUSE TO REPORT"

How would you describe the patient's race? (Please mark and "X" in the box next to the answer that best describes this.)

Race: _____ American Indian or Alaska Native
_____ Asian
_____ Native Hawaiian or another Pacific Islander
_____ Black or African American
_____ White
_____ Hispanic
_____ Another Race
_____ Unreported/Refused to report

Ethnicity:
_____ Hispanic or Latino
_____ Not Hispanic or Latino
_____ Refused to Report

Language:
_____ English
_____ Indian (includes Hindi & Tamil)
_____ Spanish
_____ Russian
_____ Other

Patient/ Guardian Signature_____ Date_____

DaVincii Ob/Gyn

CANCER FAMILY HISTORY EVALUATION

Patient Name: _____

Today's Date: _____

Your Date of Birth: _____

Reason for today's visit:

☐ NEW PATIENT ☐ PROBLEM

☐ ANNUAL APPOINTMENT/PHYSICAL ☐ OTHER (Please specify: _____)

For the following questions, please consider your mom's and dad's relatives—include first, second, and third degree relatives. This includes your children, siblings, parents, aunts/uncles, cousins, nieces/nephews, and grandparents/great grandparents.

Have you or any family members been diagnosed with:	YES	NO
Ovarian cancer **AT ANY AGE**	☐	☐
Breast cancer **BEFORE AGE 50**	☐	☐
Pancreatic cancer **AT ANY AGE**	☐	☐
THREE or more individuals on the same side of the family with breast, pancreatic, or prostate cancer **AT ANY AGE**	☐	☐
Male breast cancer **AT ANY AGE**	☐	☐
Colorectal cancer **BEFORE AGE 50**	☐	☐
THREE or more individuals on the same side of the family with colorectal and/or endometrial cancer **AT ANY AGE**	☐	☐
ONE first degree relative with colorectal or uterine cancer **BEFORE AGE 50**	☐	☐
YOU have/had colorectal or uterine cancer **BEFORE AGE 65**	☐	☐
YOU have/had breast, ovarian, or pancreatic cancer **AT ANY AGE**	☐	☐

Patient Signature: _____

☐ TeleEducation services are recommended based on genetic testing criteria:	☐ YES	☐ NO
☐ Patient completed recommended Tele Education services:	☐ YES	☐ NO
☐ Patient **DECLINED** recommended genetic test:	☐ YES	☐ NO

For patients who decline recommended education and testing: I acknowledge that I have been fully advised by my healthcare provider that my refusal to undergo recommended education and testing may delay or prevent diagnosis and treatment of significant illness, including cancer, and I am at increased risk of morbidity and mortality.

Patient signature if declining recommended testing: _____

Healthcare Provider Signature: _____

WHAT'S YOUR BEAUTY FOCUS ?

Did you know we offer various cosmetic services at DaVincii Gynecology?

Please fill out our questionnaire and return to your practitioner to be entered into a drawing to win a FREE service or product like the many below! Check or circle to indicate the procedure or treatment that interests you or that you would like to learn more about

CHECK / CIRCLE - ALL THAT APPLY

_____ Do you have melasma (dark pigment), uneven skin tone, vellus hair (peach fuzz) on your face that you would like to remove or have you been looking to refresh and brighten your skin?

_____ Do you have skin laxity, acne scars, surgical scars (face / body) stretch marks or thinning hair? Would you like to learn more about: Microneedling – PRP / PRF (Vampire Facial), Laser rejuvenation / resurfacing,

_____ Would you love to ditch the razor? Check here to learn more about laser hair removal
What area would you like to have less hair? Face Arms/ under arms Torso legs

_____ Do you suffer from the pee when you sneeze or laugh syndrome? Do you wish things were a little tighter "down there" after child birth ? Are vaginal laxity and dryness bothersome? Would you like to enhance muscle tone, strength, and elasticity of your vaginal tissue, enjoy stronger sensation during intercourse and better control over urinary incontinence?

SKIN & HAIR & WELLNESS TREATMENTS

* Medical Grade Chemical Peels * Melasma/ Sun/ Age Spots * Acne / Scars treatment
* Dermaplane Treatments (Ridding face of peach fuzz & exfoliating dead skin cells for brighter, softer skin)
* Microneedling / PRP/PRF * Laser Hair / Skin Resurfacing * IPL
* Natural Wellness Solutions – Essential oil education (better sleep/mood, de-stress, protect / boost immunity)

COSMETIC INJECTABLES: Address facial aging, deflation, wrinkles & volume

BOTOX (Juveau, Xeomin, Dysport) * Dermal Fillers – (Juvederm, Ravanesse, Restylane)

Would you like to schedule your appointment for a FREE consultation to learn more about any of the services you are interested in or enjoy an introductory lunch time facial consultation for $49 (New aesthetic patients only)

PLEASE CHOOSE HOW WE CAN HELP YOU ACHIEVE YOUR BEAUTY GOALS:

YES!! (Circle): Book my FREE consultation today * Book me for the Facial & Consult special ($49)

Please just email me information & specials_____@_____

I prefer to be texted: ( ) _____