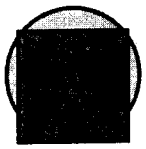

DAVINCI II
OBSTETRICS & GYNECOLOGY

1435 E. 12 Mile Road Bldg D
Madison Heights, MI 48071
Phone: 248-543-2229 ◆ Fax: 248-543-7878

Established Patient Annual Exam Checklist

Please arrive 10 minutes before your appointment time to allow for check-in and updates*

[ ] Insurance card and photo ID

[ ] Updated Patient Demographic Form

[ ] Completed Consent Form

[ ] Completed Medical History updated form

[ ] Completed Family History Questionnaire

[ ] Please be prepared to pay any outstanding balances and/or copays

DATE: _____

**Please arrive 10 minutes before your appointment time

**You must have your ID and insurance card with you

DaVincii Obstetrics and Gynecology
1435 E. 12 Mile Road (Building D)
Madison Heights, MI 48071
248-543-2229

Patient Demographic Information:

Name: _____ BD: _____ Last 4 of SS#: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: Cell: ( ) _____ Alt: ( ) _____
Email address: _____

Emergency Contact:
Name: _____ Phone: _____
Relationship: _____

Employer:
Employer Name: _____
Employer Phone Number: _____
Employer Address: _____

Referring Physician:
Name: _____ Phone: _____

Primary Physician:
Name: _____ Phone: _____

Insurance Information:

Name of Insurance: _____
Guarantor's Name (Policy Holder's Name): _____
Date of Birth of Policy Holder: _____
Policy Number: _____

Pharmacy Information:
Name: _____ Phone: _____
Address (cross streets): _____
City: _____

Established Patient Consent Form

Please initial and sign where indicated:

____ It is not possible to know and maintain current coverage and plan information for everyone's individual policy. It is your responsibility to to be aware of your benefits and coverages. Your deductible is your contracted amount with the insurance company and must be paid as part of your services rendered.

____ We use **Lab Corp** as our in office laboratory testing. It is your responsibility to know if your insurance requires a particular lab and you MUST inform us of this prior to the tests being sent out. You are responsible for all cost incurred by the lab. Laboratory testing is not included in the physician's fee for the exam you receive.

____ All of our patient's billing is done through a computer system and company off site. We must have a signature on file and a release of medical information in order to receive payment or reimburse you for any overpayments.

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.

Signature: _____ Date: _____

____ I authorize payment to my physician for services rendered. I also am responsible for any co-pays and/or deductibles required by my particular insurance company plan.

____ There is a $50.00 fee for appointments that are not cancelled within 24 hours.

____ There will be a $10 fee added to each additional billing statement after the first one if prompt payment is not received. Any person not current in their payments will be sent to collections and will not be able to make a future appointment without the balance being paid. Payment plans are available and can be arranged with the office. Any payments not received per the payment plan schedule will be charged $25.00

____ I acknowledge that the DaVincii Obstetrics and Gynecology 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, the payment of my bills, in the performances of health care operations of DaVincii Obstetrics and Gynecology and my rights and the duties of DaVincii Obstetrics and Gynecology with respect to my protected health information. The Notice of Privacy Practices also may be provided upon request at the desk. The Notice of Privacy Practices my be changed at the discretion of DaVincii Obstetrics and Gynecology and a copy may be requested at any time.

Signature: _____ Date: _____

____ This office will e-prescribe prescriptions provided to you. DaVincii Obstetrics and Gynecology may view your external history prescriptions. Any patient requesting or requiring a controlled substance will be viewed under the MAPS program to comply with federal requirements.

I acknowledge that I have carefully read the above information and that I have provided my signature and initials where indicated.

Signature: _____ **Date:** _____

Established Patient Medical History

Name: _____ BD: _____

If you are here for an annual visit, we will be updating your medical history and performing a breast and pelvic exam. If you are having any other gynecological concerns, please let us know so we can schedule a follow up visit to address these concerns.

Current Medications:

Name	Dose	Name	Dose

Medical History:

High Blood Pressure.....[ ] Diabetes.....[ ] High Cholesterol.....[ ] Anemia.....[ ]

Heart Disease.....[ ] Stroke.....[ ] Asthma.....[ ] Anxiety.....[ ]

Depression.....[ ] Migraines.....[ ] Arthritis.....[ ] Seizures.....[ ]

Thyroid Disease.....[ ] Osteoporosis....[ ] Blood Clots.....[ ] IBS>>>.....[ ]

Cancer.....[ ] Type of Cancer:_____ Age of Diagnosis: _____

Have you ever been hospitalized overnight? If yes, for what?

_____

Allergies to Medications:

Medication	Reaction

Surgical History: *(Please list all surgeries that you have had)*

_____ _____ _____

_____ _____ _____

Gynecological History:

Age of first period? _____ If menopausal, when was your last period? _____

How often do you get a period? _____ How many days do you bleed? _____

History of abnormal PAP smears?

No [ ]

Yes [ ] Procedures performed on cervix _____

Any history of sexually transmitted infections? (If yes, please specify which infections)

No [ ]

Yes [ ] _____

Are you currently sexually active? Yes [ ] No [ ]

If yes, with men, women or both? _____

Do you use any form of birth control (please specify if yes) No [ ] Yes [ ] _____

Health Maintenance: *(If applicable)*

Last PAP Smear: _____ Last mammogram: _____

Last colonoscopy: _____ When is your next colonoscopy due? _____

Vaccine History: Please mark if you have received any of the following vaccines

Flu [ ] Covid [ ] Gardasil [ ] Shingles [ ]

Obstetrical History: *Please record the number of*:

Pregnancies: _____ Living children: _____ Vaginal births: _____ C-sections: _____

Ectopics: _____ Terminations: _____ Miscarriages: _____

Personal/Social History:

Are you [ ] Married Partner's name: _____

[ ] Single [ ] Widowed [ ] Divorced [ ] Same sex partner [ ] Long term relationship

Do you work? No [ ] Yes [ ] Type of occupation: _____

Do you smoke: No [ ] Yes [ ] How much per day? _____

Do you drink alcohol: No [ ] Yes [ ] How many drinks per week? _____

Do you take any non-prescribed drugs: No [ ] Yes [ ] What kind _____

History of emotional, physical or sexual abuse? No [ ] Yes [ ]

DaVincii Ob/Gyn

CANCER FAMILY HISTORY EVALUATION

Patient Name: _____

Today's Date: _____

Your Date of Birth: _____

Provider seeing you today: _____

1st Degree relatives: Mom, Dad, Brothers, Sisters, Sons, daughters

2nd Degree relatives: Aunts, Uncles, Grandparents, Nieces, Nephews

3rd Degree relatives: Great Grandparents, Great Aunts/Uncles, cousins

Have you or any family members been diagnosed with:	YES	NO
Ovarian cancer **AT ANY AGE**, 1st or 2ND degree relative	☐	☐
Breast cancer **BEFORE AGE 50**, 1st or 2nd degree relative	☐	☐
Pancreatic cancer **AT ANY AGE**, 1st degree relative, *(1st or 2nd, BCBS MI)	☐	☐
THREE or more individuals on the same side of the family with breast, pancreatic, or prostate cancer **AT ANY AGE**, any degree relative	☐	☐
Male breast cancer, (1st or 2nd) **OR** metastatic prostate cancer (1st) **AT ANY AGE**	☐	☐
2 Colorectal and/or Uterine cancers **1 before age 50**, 1st or 2nd degree	☐	☐
THREE or more individuals on the same side of the family with colorectal and/or endometrial cancer **AT ANY AGE**, Any degree relative	☐	☐
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: _____