2695 Ulmerton Rd.
Clearwater, FL 33762
Phone: (727) 540-0414
Fax: (727) 540-0672

Visionary Centre for Women

JENNIFER S. HAYES DO, FACOOG

Today's Date: _____

Patient Name: _____ _____ ____
Last First M.I.

Home Address: _____
Street Apt# City State Zip

Birt□ Date: _____/_____/_____ Age: _____ SS # _____-_____-_____

Home # (_____)_____ Cell # (_____)_____ Work # (_____)_____

E-mail: _____

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Spouse Name (if applicable): _____ Phone # (_____) _____

Emergency Contact:_____ Phone # (_____) _____

How Would You Most Like Us to Contact You?: ☐ Cell ☐ Text ☐ E-mail ☐ Home Phone ☐ Work

Primary Care Physician: _____ Phone # (_____) _____

Pharmacy Name: _____ Phone # (_____) _____

Imaging Center _____ Phone # (_____) _____

Lab Name: _____ Phone # (_____) _____

HOW DID YOU HEAR ABOUT US?

☐ You've Been a Patient of Dr. Hayes ☐ In-Office – Current Patient/Staff Member _____

☐ Friend / Family Who may we thank?_____

☐ Physician / Healthcare Provider Who may we thank?_____

☐ Internet – Google/Yahoo/OnlineSurgery.com/Other Site: _____

☐ Media / TV / Lecture / Seminar _____

☐ Print Advertising ☐ TampaBay Metro ☐ Feather Sound News ☐ West Coast Women ☐ Other_____

☐ Real Self ☐ BioTe.com ☐ O-hot.com

☐ ***Check if you would like to receive our quarterly health updates.***

RELEASE OF INFORMATION: *We will only discuss your protected health information (PHI) with you unless you authorize us to discuss it wit□ someone else. Please list below the name(s) of individuals you authorize our office to discuss your care with. If this list changes, please notify us in writing.*

_____ _____

_____ _____

Notice of Privacy Practices: I acknowledge that I have been offered a copy of our "Notice of Privacy Practices" and I have read and understand the above and agree to comply. *(You will be given a copy of Notice of Privacy Practices at your first visit.)*

Patient's Signature: _____ Date: _____/_____/_____

REASON FOR VISIT TODAY

REVIEW OF SYSTEMS

Please check any problems you are currently having.

1. **General:** ☐ fever ☐ chills ☐ weight loss ☐ weight gain ☐ fatigue ☐ insomnia
2. **Eyes, Ear, Nose & Throat:** ☐ vision changes ☐ glasses or contacts ☐ headache ☐ hearing loss ☐ sinusitis
3. **Cardiovascular:** ☐ swelling of legs ☐ chest pain ☐ dizzy spells ☐ fainting ☐ difficulty breathing with exertion ☐ rapid hart beat ☐ irregular heartbeat
4. **Respiratory:** shortness of breath ☐ wheezing ☐ cough ☐ coughing up blood
5. **Gastrointestinal:** ☐ constipation ☐ diarrhea ☐ bloody stool ☐ nausea ☐ vomiting ☐ indigestion ☐ fecal incontinence ☐ flatulence
6. **Genitourinary:** ☐ burning with urination ☐ night time urination ☐ frequent urination ☐ trouble emptying your bladder leaking urine ☐ blood in urine ☐ infertility
7. **Musculoskeletal:** ☐ muscle weakness ☐ muscle pain ☐ joint pain ☐ back pain
8. **Skin:** ☐ dry ☐ rash ☐ itch ☐ ulcers ☐ pigmented lesions ☐ change in moles
9. **Breasts:** ☐ pain ☐ lump ☐ nipple discharge
10. **Neurologic:** ☐ fainting ☐ seizures ☐ numbness ☐ severe memory problems ☐ migraine ☐ headaches ☐ trouble walking ☐ ringing in ears
11. **Psychiatric:** ☐ anxiety ☐ depression ☐ crying spells ☐ mood swings
12. **Endocrine:** ☐ hair loss ☐ heat or cold intolerance ☐ excessive sweating ☐ excessive thirst
13. **Hematologic:** ☐ bleeding ☐ bruising ☐ swollen lymph nodes

PERSONAL PAST HISTORY

☐ Anemia	☐ Diets	☐ Lupus
☐ Arthritis	☐ Eating Disorder	☐ Mitral Valve Prolapse
☐ Asthma	☐ Fibroids	☐ Obesity
☐ Blood Clots (legs/Lungs)	☐ Heart Disease	☐ Osteoporosis
☐ Blood Transfusions	☐ Heart Murmur	☐ Pneumonia
☐ Bowel Problems	☐ Hepatitis	☐ Reflux
☐ Broken Bones	☐ Herpes or Genital Warts	☐ Rheumatic Fever
☐ Cancer (location _____)	☐ HIV (known exposure)	☐ Seizures
☐ Chicken Pox	☐ High Blood Pressure	☐ Stroke
☐ Chlamydia or Gonorrhea	☐ High Cholesterol	☐ Syphilis
☐ Depression	☐ Infertility	☐ Thyroid Disease
☐ Diabetes	☐ Kidney Stones	☐ Tuberculosis

SURGICAL HISTORY

List all Surgeries: _____

_____

List all Hospitalizations: _____

_____

HEALTH

Screenings	Date of last Pap? _____ Last mammogram? _____ Last bone density? _____
	Have you ever had abnormal Pap? ☐ yes ☐ no Last Colonsocopy? _____
	_____
Exercise	☐ Sedentary (no exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 block, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.)
Diet	Are you dieting? ☐ yes ☐ no Describe _____
	Are you on a physician prescribed medical diet? ☐ yes ☐ no Which one? _____
	# of meals you eat in an average day? _____ Glasses of water per day?_____
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Soda ☐ None ☐ Energy Drink
	# of cups or cans a day? _____
Alcohol	Do you drink alcohol? ☐ yes ☐ no
	# of glasses/cans per week? _____
Tobacco	Do you use tobacco? ☐ yes ☐ no # cigarettes per day? _____ # of years? _____
	or # of years quit? _____
Drugs	Do you currently use recreational or street drugs? ☐ yes ☐ no
Vital Stats	Height _____ Current Weight _____ Maximum Weight _____

List your current **Prescription Medications, Herbs, Vitamins**, appetite suppressants, over-the-counter meds

Name the Drug	Strength	Frequency Taken

List all **Allergies:** _____

_____

_____

FAMILY HISTORY

Does anyone in your family have any of the following (check and list relative)

- ☐ Arthritis (Lupus) _____
- ☐ Blood Clots _____
- ☐ Breast Cancer _____
- ☐ Colon Cancer _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Ovarian Cancer _____
- ☐ Kidney Disease _____
- ☐ Osteoporosis _____
- ☐ Seizures _____
- ☐ Stroke _____
- ☐ Uterine Cancer _____

Mother: Age _____ If deceased, cause of death and age _____

Father: Age _____ If deceased, cause of death and age _____

OBSTETRICAL HISTORY

List ALL births, ectopics, miscarriages and terminations:

_____

_____

_____

Birth Year	Birth Weight	Baby's Sex	Type of Delivery	Complications

UROGYN HISTORY

Age at onset of menstruation? _____ First day of last menses? _____

Heavy periods, irregularity, spotting, pain, or discharge? _____

Period every_____days? Length of periods? _____

Any changes in your period? _____

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?

☐ yes ☐ no _____

Are you currently sexually active? ☐ yes ☐ no ☐ Men ☐ Women ☐ Both

Libido issues? _____

What type of contraception are you using? _____ # of lifetime sexual partners? _____

Any hot flashes or sweating at night? ☐ yes ☐ no Insomnia? ☐ yes ☐ no

Any Hair loss? ☐ yes ☐ no Energy/Vitality issues? ☐ yes ☐ no

Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ yes ☐ no

Any problems with control of urination? ☐ yes ☐ no _____

Any discomfort or loss of sensation with intercourse? ☐ yes ☐ no _____

Any vaginal dryness, discharge, irritation or odor? ☐ yes ☐ no _____

Ever have kidney infection? ☐ yes ☐ no

Bladder infection? ☐ yes ☐ no

Visionary Centre for Women

HEALTH ASSESMENT

Name: _____ **Date:** _____

E-Mail Address: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Depressive mood (feeling down/sad/lack of drive)				
Memory Loss (forgetfulness)				
Mental confusion (feeling in a mental fog)				
Decreased sex drive/libido (decreased desire for sex)				
Sleep problems (difficulty falling/staying asleep/wake up tired)				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Other symptoms that concern you:

VISIONARY CENTRE FOR WOMEN
FINANCIAL POLICY AND AGREEMENT

Thank you for choosing Visionary Centre for Women for your medical and cosmetic needs. We are committed to providing you with excellent care and convenient financial arrangements. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patient's financial capabilities. To confirm your understanding and agreement with our policies, please read the following:

PAYMENT: Payment is due in full is due at time of service. Our practice accepts cash, checks, Visa, MasterCard, American Express and Discover cards. We find that some of our patients prefer to divide the cost of treatment up into equal monthly payments using an outside financing arrangement.

INSURANCE: Insurance is a contract between the patient and/or employer and the insurance company. It is not a contract between our office and your insurance company. Our office is committed to providing you with a receipt that will contain all of the tools you need to submit to your insurance for possible reimbursement, however we will not submit insurance claims or correspond with your insurance regarding your claim on your behalf.

RECURRENT MISSED APPOINTMENTS: Once an appointment has been made, please remember that this time has been reserved specifically for you. We reserve the right to charge a $50.00 fee for recurrent missed appointments without 24 hour notice.

SERVICE CHARGE: We will charge $50 for returned checks. Collection Fees, in addition to the outstanding account balance and all fees incurred to collect payment (including collection agency and legal fees) will be billed to and payable by the patient's account holder.

FINANCIAL CONSENT: The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office. I understand and agree to this Financial Policy and Agreement.

_____ _____/_____/_____

Patient/Guardian/Financial or Responsible Party (SIGN) Date:

_____ _____/_____/_____

Patient/Guardian/Financial or Responsible Party (PRINT) Date:

VISIONARY CENTRE FOR WOMEN INFORMED PATIENT CONSENT

☐ I give my permission for the Physician or Advanced Registered Nurse Practitioner (ARNP) and staff to treat me as deemed necessary in the exercise of their professional judgment.

☐ I understands that medical care requires my cooperation, and I will follow my Doctor or ARNP's orders and prescriptions if indicated. I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

☐ I understand that I may be billed by an outside laboratory for work that is performed in the office, if my insurance company does not have a contracted lab or facility, or if laboratory services are not covered by my insurance.

☐ I acknowledge that I have been informed of my responsibility to pay for the professional services and/or supplies provided to me today by Visionary Centre for Women, I understand that these costs must be paid prior to the provision of such services. I acknowledge and fully understand that the service(s) requested today will not be billed to any insurance carrier(s). I further acknowledge that if I choose to submit an itemized receipt to any insurance carrier(s) for evaluation of partial or full reimbursement for these services that Visionary Centre for Women is exempt from any subsequent dispute regarding reimbursement.

_____ _____/_____/_____

Patient/Guardian/Financial or Responsible Party (SIGN) Date:

_____ _____/_____/_____

Patient/Guardian/Financial or Responsible Party (PRINT) Date:

VISIONARY CENTER FOR WOMEN PATIENT RIGHTS & RESPONSIBILITIES

You Have The Right:

- To be treated with respect, consideration and dignity, without discrimination on the basis of race, color, sex, religion, or national origin.
- To know the policy on rights and responsibilities you have as a patient.
- To participate in decisions involving your health care; to be assisted in the development of advance directives, and to know and take responsibility for the consequences of refusing treatment or not complying with therapy.
- To receive services in a safe and clean environment.
- To privacy and confidentiality and to approve or refuse the release of your medical records, except when release is required.
- To receive information concerning your diagnosis, treatments, and prognosis; and to accept or refuse treatment after full information is given.
- To know what provisions are available for after hours and emergency coverage; and to have access to an interpreter as needed in order to understand explanations.
- To know the fees for services provided and the policies regarding the payment of fees.
- To be free from abuse or neglect; to access protective services.
- To be referred to specialists and other professionals when needed and to change physicians if you are not satisfied and if other qualified physicians are available.
- To voice a compliment or complaint by calling (727) 540-0414 or fax: (727) 540-0672 or e-mail: cformico@drjenniferhayes.com.

You Have The Responsibility:

- To provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
- To follow the treatment plan recommended by the practitioner responsible for your care; and for your actions if you refuse treatment or do not follow the practitioner's instructions.
- To keep appointments and, when unable to do so for any reason, to notify our office within 24 hrs.
- To ensure that the financial obligations of your health care are fulfilled as promptly as possible.
- To be considerate of the rights of other patients and personnel.
- To be respectful of the property of others.
- To ask for clarification when explanations regarding your treatment have not been given to your satisfaction.

ABOUT ADVANCE DIRECTIVES

Upon registration, we will ask you if you have an advance directive. An advance directive is a written document which communicates your health care wishes clearly.

There are two types of advance directives:

A Durable Power of Attorney for Health Care - is a document that allows you to designate another person (known as a proxy agent) who is at least 18 years of age to make medical decisions for you in the event you are unable to do so. These decisions may include, but are not limited to, the withholding or withdrawal of life prolonging procedures.

A Living Will or Health Care Directive - is a document that allows you to state in advance your wishes regarding the use of certain medical procedures and treatments and becomes effective when you are unable to make your own decisions and can no longer communicate such decisions. It serves as a guide to your family or the person you name as your agent.

_____	_____	_____
Name of Patient	Signature of Patient	Date Time
_____	_____	_____
Name of Legal Authorized Person	Signature of Legal Authorized Person	Date Time
_____	_____	_____
Name of Witness	Signature of Witness	Date Time