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Clearwater, FL 33762  
Phone: (727) 540-0414  
Fax: (727) 540-0672



JENNIFER S. HAYES DO, FACOOG

Today's Date: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
Last First M.I.

Home Address: \_\_\_\_\_  
Street Apt# City State Zip

Birth 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

Current Health Insurance: \_\_\_\_\_

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-Shot.com  Morning Blend  Event \_\_\_\_\_

**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 with 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**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Eating Disorder      | <input type="checkbox"/> Menstrual Headaches   |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Fibroids             | <input type="checkbox"/> Migraines             |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Frequent Headaches   | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Blood Clots (legs/Lungs) | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Osteoporosis          |
| <input type="checkbox"/> Blood Transfusions       | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pneumonia             |
| <input type="checkbox"/> Bowel Problems           | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Reflux                |
| <input type="checkbox"/> Broken Bones             | <input type="checkbox"/> Herpes Genital Warts | <input type="checkbox"/> Rheumatic Fever       |
| <input type="checkbox"/> Cancer (location _____)  | <input type="checkbox"/> HIV (known exposure) | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Chicken Pox              | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Chlamydia or Gonorrhea   | <input type="checkbox"/> High Cholesterol     | <input type="checkbox"/> Syphilis              |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Infertility          | <input type="checkbox"/> Thyroid Disease       |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Kidney Stones        | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Diets                    | <input type="checkbox"/> Lupus                | <input type="checkbox"/> Covid-19              |

**SURGICAL HISTORY**

List all Surgeries: \_\_\_\_\_  
\_\_\_\_\_  
List all Hospitalizations: \_\_\_\_\_  
\_\_\_\_\_

**HEALTH**

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

- |  |   |
|--|---|
| <input type="checkbox"/> Arthritis (Lupus) _____   | <input type="checkbox"/> Ovarian Cancer _____ |
| <input type="checkbox"/> Blood Clots _____         | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Breast Cancer _____       | <input type="checkbox"/> Osteoporosis _____   |
| <input type="checkbox"/> Colon Cancer _____        | <input type="checkbox"/> Seizures _____       |
| <input type="checkbox"/> Diabetes _____            | <input type="checkbox"/> Stroke _____         |
| <input type="checkbox"/> Heart Disease _____       | <input type="checkbox"/> Uterine Cancer _____ |
| <input type="checkbox"/> High Blood Pressure _____ |   |

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



## HEALTH ASSESMENT

Name: \_\_\_\_\_

Date: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

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

Other symptoms that concern you:


**COSMETIC GYNECOLOGY INTAKE FORM**

**NATURE OF THIS VISIT:**

**For Labiaplasty**

- Unhappy with appearance due to length or asymmetry or pigmentation
- Unable to wear certain clothes/lingerie/bikinis
- Inhibiting with sexual activity, self-conscious, and embarrassed due to extra tissue
- Pulling/discomfort/irritation/pain with intercourse
- Pulling/discomfort/irritation/pain with certain activities/exercise/clothing
- Irritation with prolonged sitting or walking
- Multi-directional urine stream
- Hygiene issues
- Previous Labia Minora Reduction surgery desiring evaluation for surgical correction

**For Labia Majora Reduction**

- Sagging Labia Majora (Outer lips)
- Appearance issue
- Comfort issue and/or function issue (pain/discomfort with intercourse)

**For Clitoral Hood Reduction**

- Excess Prepuce
- Pigmentation
- Asymmetry
- Hygiene
- Problems with access to Clitoris

**For Vaginal Rejuvenation**

- Decreased sensation with intercourse for one/both partners
- Partner falls out with thrusting
- Gas-like noises during intercourse
- Problems with tampon use
- Have to manually express stools
- Have to support perineum with BMs
- Leaking urine  daily  weekly  monthly
- Passes stool with intercourse
- Scar tissue at vaginal opening or on perineum
- Strain, push or bend over to help urine come out

**For Hymen Restoration**

- Desires Hymen reconstruction

**For G-shot**

- Have experienced vaginal orgasm

**For Mons Liposuction**

- Localized Mons adiposity(fat) desiring reduction
- Unable to wear certain clothing
- Previous Abdominoplasty with residual localized Mons adiposity (fat)

**Other:** \_\_\_\_\_

## **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, and most credit cards.

**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.

**REFUNDS:** There is a 5% service fee deducted from any credit card refund.

**CANCELLED APPOINTMENTS:** If your appointment required a \$100 deposit, we require 72 hour cancellation notice, excluding weekends to receive your deposit. You may reschedule your appointment, one time only, and use your deposit.

**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 understand that medical care requires my cooperation, and I will follow my Dr.Hayes'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.
  
- A pelvic exam is an exam of the vagina, cervix, uterus, fallopian tubes, ovaries and rectum or external pelvic tissues or organs. The procedure is used to diagnose and or/ treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation. By signing this, I authorized Dr Jennifer Hayes to perform a pelvic exam.
  
- 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 item-ized 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: mkinzer@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