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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"/> Diets | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Obesity |
| <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 or 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 |

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? <input type="checkbox"/> yes <input type="checkbox"/> no Last Colonoscopy? _____
Exercise	<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.)
Diet	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? _____
Caffeine	<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? _____
Alcohol	Do you drink alcohol? <input type="checkbox"/> yes <input type="checkbox"/> no
	# of glasses/cans per week? _____
Tobacco	Do you use tobacco? <input type="checkbox"/> yes <input type="checkbox"/> no # cigarettes per day? _____ # of years? _____
	or # of years quit? _____
Drugs	Do you currently use recreational or street drugs? <input type="checkbox"/> yes <input type="checkbox"/> 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)

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

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, 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 \$25 fee for *same day cancellations* or *no shows* and 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 3% service fee deducted from any credit card refund.

CANCELLED APPOINTMENTS: To get a refund for a cancelled appointment that required a \$100 deposit, we need 72 hours notice, excluding weekends. You may reschedule your appointment, one time only, and use your deposit. If you no show or cancel the same day, you forfeit your \$100 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