Date _____
Fecha

Patient Registration
Registración del Paciente

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

Patient Information - *Información del Paciente*

Social Security # _____
Numero de Seguro Social

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*

Last Name _____
Apellido

Sex _____ Date of Birth ____/____/____
Sexo *Fecha de Nacimiento*

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Estado Civil *Casada* *Soltera* *Divorciada* *Viuda*

Race/Ethnicity _____
Raza/Etnia

(Check One) ☐ Employed ☐ Retired ☐ Full-Time Student
Marque Uno *Empleada* *Retirada* *Estudiante Tiempo Completo*

☐ Other _____
Otro

Employer _____
Empleador

Work Phone (____) _____
Telefono de Trabajo

Home Address _____
Direccion del Hogar

City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Email Address _____

Home Phone (____) _____ Cell Phone (____) _____
Telefono del Hogar *Telefono Cellular*

I was referred to: _____ by / *por*
Fui recomendado por

☐ Friend _____ ☐ Relative _____
Amigo *Familiar*

☐ Physician _____ ☐ Insurance _____
Médico *Seguro*

☐ Reputation of the LLC's Physicians _____
Reputación de los Médicos del LLC

☐ Existing Patient of the LLC _____
Paciente Existente de la LLC

☐ Other _____
Otro

Insurance Information - *Información del Seguro*

Please provide your insurance card to the receptionist - *Por favor entregue su tarjeta de seguro a la recepcionista*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

Insurance company _____
Compañia de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado *Relación*

Policy # _____ Group # _____ Phone (____) _____
Numero de Poliza *Numero de Grupo* *Telefono*

Secondary Insurance Information - *Información del Seguro Secundario*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

Insurance company _____
Compañia de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado *Relación*

Policy # _____ Group # _____ Phone (____) _____
Numero de Poliza *Numero de Grupo* *Telefono*

Emergency Contact - *En Emergencias, contactar a:*

Social Security # _____
Numero de Seguro Social

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*

Last Name _____
Apellido

Sex _____
Sexo

Home Phone (____) _____
Telefono del Hogar

Work Phone (____) _____
Telefono del Trabajo

Pharmacy - *Farmacia*

Pharmacy _____
Farmacia

Pharmacy Phone _____
Numero de telefono de la farmacia

Pharmacy Address _____
Direccion de la farmacia

Spouse / Guarantor / Responsible Party - *Esposo / Persona Responsable*

Social Security # _____
Numero de Seguro Social

Relationship _____
Relación

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*

Last Name _____
Apellido

Address _____
Direccion

City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Sex _____ Date of Birth ____/____/____
Sexo *Fecha de Nacimiento*

Daytime Phone (____) _____
Teléfono durante el dia

Employer _____
Empleo

Address _____
Direccion

City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Signature Required Please See Reverse Side
Firma Requerida, Por Favor mira al Dorso

DELISA SKEETE HENRY, M.D., LLC.

ANTEPARTUM RECORD

DATE _____

NAME _____
LAST FIRST MIDDLE

ID# _____ HOSPITAL OF DELIVERY _____

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

FINAL EDD _____ PRIMARY PROVIDER/GROUP _____

BIRTHDATE	AGE	RACE	MARITALSTATUS (S M W D SEP)	ADDRESS

OCCUPATION
☐ HOMEMAKER
☐ OUTSIDE WORK
☐ STUDENT Type of Work

EDUCATION (LAST GRADE COMPLETED)

ZIP PHONE (H) (O)

INSURANCE CARRIER/MEDICAID#

HUSBAND/FATHER OF BABY PHONE

EMERGENCY CONTACT PHONE

TOTAL PREG	FULLTERM	PREMATURE	AB.INDUCED	AB.SPONTANEOUS	MULTIPLE BIRTHS	ECTOPICS	LIVING

MENSTRUAL HISTORY

LM ☐ DEFINITE ☐ UNKNOWN ☐ FINAL _____ ☐ APPROXIMATE (MONTH KNOWN) ☐ NORMAL AMOUNT / DURATION

MENES MONTHLY ☐ YES ☐ NO PRIOR MENES _____ DATE

FREQUENCY: Q _____ DAYS ONBCPATCONCEPT. ☐ YES ☐ NO

MENARCH _____ (AGE ONSET) hCG+ ____/____/____

PAST PREGNANCIES (LAST SIX)

DATE MONTH/ YEAR	GA WEEKS	LENTGH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES	PLACEOF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/COMPLICATIONS

PAST MEDICAL HISTORY

	ONeg +Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1.DIABETES		
2.HYPERTENSION		
3.HEART DISEASE		
4.AUTO IMMUNE DISORDER		
5.KIDNEY DISEASE/UTI		
6.NEUROLOGIC/EPILEPSY		
7.PSYCHIATRIC		
8.HEPATITIS/LIVER DISEASE		
9.VARICOSITIES/PHLEBITIS		
10.THYROID DYSFUNCTION		
11.TRAUMA/DOMESTIC VIOLENCE		
12.HISTORY OF BLOOD TRANSFS		

	AMT/DAY PRE-PREG	AMT/DAY PRE-PREG	#YEARS USE
13.TOBACCO			
14.ALCOHOL			
15.STREET DRUGS			

	ONeg +Pos	DETAIL, POSITIVE REMARKS INCLUDE DATE & TREATMENT
16.D(Rh) SENSITIZED		
17.PULMONARY (TB,ASTHMA)		
18.ALLERGIES (DRUGS)		
19.BREAST		
20.GYN SURGERY		
21.OPERATION/HOSPITALIZATIONS (YEAR & REASON)		
22.ANESTHETIC COMPLICATIONS		
23.HISTORY OF ABNORMAL PAP		
24.UTERINE ANOMALY / DES		
25.INFERTILITY		
26.RELEVANT FAMILY HISTORY		
27.OTHER		

COMMENTS: _____

Date: _____

Patient Name: _____ Date of Birth: _____

SYMPTOMS SINCE LMP

	YES	NO		YES	NO
1.PATIENT'S AGE(35 OR OLDER)			12.MENTAL RETARDATION / AUTISM		
2.THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN,OR ASIAN BACKGROUND) MCV<80			IF YES,WAS PERSON TREATED FOR FRAGILEX?		
3.NEURAL TUBE DEFECT (MENINGOMYELOCELE,SPINABIFIDA,ORANENCEPHALY)			13.OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
4.CONGENITAL HEART DEFECT			14.MATERNAL METABOLIC DISORDER (EG.INSULINDEPENDENT DIABETES,PKU)		
5.DOWN SYNDROME			15.PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
6.TAY-SACHS(EG.JEWISH,CAJUN,FRENCH-CANADIAN			16.RECURRENT PREGNANCY LOSS,OR A STILL BIRTH		
7.SICKLE CELL DISEASE OR TRAIT(AFRICAN)			17.MEDICATIONS/STREET DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
8.HEMOPHILIA			IFYES,AGENT(S)		
9.MUSCULAR DYSTROPHY			18.ANY OTHER		
10.CYSTIC FIBROSIS					
11.HUNTINGTON CHOREA					

COMMENTS/COUNSELING _____

INFECTION HISTORY	YES	NO		YES	NO
1.HIGH RISK HEPATITIS B / IMMUNIZED?			4.RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD		
2.LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			5.HISTORY OF STD.GC.CHLAMYDIA.HPV.SYPHILIS		
3.PATIENT OR PARTNER HAS HISTORY OFGENITAL HERPES			6.OTHER(SEE COMMENTS)		

COMMENTS _____

INTERVIEWER'S SIGNATURE _____

DELISA SKEETE HENRY, M.D., LLC.

PATIENT CONSENT FORM

PATIENT FINANCIAL RESPONSIBILITY: Co-pays, deductibles and co-insurance applied to the visit will be collected at the time of service.

INSURANCE: We will bill your insurance company for your visit AS A COURTESY to You. Due to difficulty obtaining payment for your insurance plans, we may ask for your assistance in getting your claim paid. Please be advised that it is the patient's responsibility to verify that we are a participating provider with your insurance plan, and to verify patient financial responsibility for today's visit.

HMO/REFERRALS: It is your responsibility to obtain a referral from your primary care physician if your insurance carrier requires it for your visits. It is the patient's responsibility to know and understand the requirement of your insurance plan. Our office is not responsible to obtain referrals for patients on HMO plans. If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.

MINOR PATIENTS: The parent or guardian accompanying a minor is responsible for payment of the bill.

RETURNED CHECKS: Checks returned for any reason will be subject to all bank fees charged to us along with 5% of the face value of the check or $25.00 administrative fee (whichever is greater).

COLLECTIONS: Should your account become a collections problem, the patient/debtor assumes all costs of collections including but not limited to collection agency fees, court costs, interest and legal fees. **All unpaid accounts will be reported to the credit bureau.**

NON-COVERED SERVICES: You will be responsible for payments of service **"NOT COVERED"** by your insurance plan. It is your responsibility to understand your insurance plan's benefit and / or limitations.

Disclosure of Health Information to Health Provider: I hereby authorize Delisa Skeete Henry, M.D., LLC. to furnish information to my insurance carriers and I hereby irrevocably assign to Delisa Skeete Henry, M.D., LLC, all payment for medical service rendered. I understand that I am financially responsible for all charges whether or not covered by insurance, and all cost of collection, should the account become delinquent and need to be referred to a collection agency.

HIPAA ACKNOWLEDGEMENT: We are required to provide you with a copy of Notice of Privacy Practices, which states how we may use and / or disclose your health information.

MALPRACTICE INSURANCE: Under the Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical practice.

YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law. Florida Statue 458.320(5)(g)(1).

NORMAL LAB RESULTS

I _____ authorize for Dr. Delisa Skeete Henry's Office to text my Normal Lab results to the cell number given to the office.

Please sign this form as an acknowledgement that you have read and agree to the above information.

Print Patient Name: _____

Patient responsibility party signature: _____ Date: _____

Notice of Privacy Practices

Delisa Skeete Henry, M.D., LLC.

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices-We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure-This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication–This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI-This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI-This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information-This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability-This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice-You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our HIPAA Compliance Officer. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment-We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices-We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment- Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations-We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization-The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare -Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures-We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the HIPAA Compliance Officer at: **[PRACTICE PHONE #_____]**

We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Effective Date: 04/2003
Revised: 06/2013

Welcome to Dr. Skeete Henry's Practice

Dear valued patient:

We are so thankful that you have entrusted this practice for your health care needs. Our mission is to provide a positive environment for your obstetrical and gynecological needs. Our goal is for you to feel at home in our office. We aim to exceed the standards of care & provide superb health care.

Be sure to bring your driver's license and insurance card with you at the time of your visit. We also recommend that you contact your insurance company for more information on patient financial responsibilities.

Please be prepared to pay copay, deductible or co-insurance applied to your first visit.

Self-Patient: If you are a self-pay patient coming for an annual visit; please bring a cashier's check, money order or debit card to pay directly to the lab company for your pap smear.

We respect our patients and value their time and as a result we do not double-book appointments. Please be on time, as we are committed to giving each patient personalized, quality attention. **If you are running more than 15 minutes late, we will reschedule your appointment to the next available date**. If you are a patient transferring from another physician's office, please bring your medical records with you.

Address to our office: **1625 S. E. 3rd Avenue, Suite # 502, Fort Lauderdale, FL 33316**

We are located in Medical Office Building (MOB), inside Broward Health Medical Center on Andrews Avenue. There ***is complimentary valet parking*** *available at* ***the main entrance*** *of the hospital and on* ***S.E 3rd Avenue.*** *Or you can choose to park your vehicle inside the parking garage adjacent to the hospital.*

Please check out our website: www.skeetehenryobgyn.com

BOOK AN APPOINTMENT via email: drskeetehenryobgyn@femwell.com

We are looking forward to seeing you.

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician: _____

Date of Birth: _____ Today's Date: _____

This is a screening tool for cancers that run in families. Please consider these family members when completing the form:

Mother/Father/Sister/Brother/Children = 1st Degree Relatives

Aunt/Uncle/Grandparent/Niece/Nephew = 2nd Degree Relatives Cousin/Great Grandparent = 3rd Degree Relatives

Have you or any of your relatives been tested for a hereditary cancer syndrome (BRCA/Colaris) in the past? YES NO

Have you ever been diagnosed with cancer? What site: _____ Age: _____

		COLON AND UTERINE CANCER (Lynch Syndrome/Colaris)	SELF	YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
(Y)	N	***EXAMPLE: Two or more relatives with a Lynch syndrome cancer; one under age 50***			***Aunt-colon Sister-uterine***	***47 yrs 60 yrs***
Y	N	Have **YOU** been diagnosed with uterine (endometrial) or colorectal cancer before age 50				
Y	N	Two or more relatives on the same side of the family w/ any of the following, one diagnosed before 50 **(please circle):** *colon, uterine/endometrial, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter and renal pelvis*				
Y	N	Three or more relatives on the same side of the family w/ any of the following diagnosed at any age **(please circle):** *colon, uterine/endometrial, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter and renal pelvis*				
		BREAST AND OVARIAN CANCER (HBOC/BRACAnalysis)	**SELF**	**YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER**		**AGE AT DIAGNOSIS**
				MOTHER'S SIDE	**FATHER'S SIDE**	
Y	N	Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	N	Ovarian cancer at any age (in self, first or second degree family members)				
Y	N	Two relatives on the same side of the family with breast cancer—with one under the age of 50				
Y	N	Three relatives on the same side of the family with breast, aggressive prostate, pancreatic or ovarian at any age				
Y	N	Multiple breast cancers in the same person (in the same breast or in both breasts)				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with breast, ovarian, aggressive prostate or pancreatic cancer at any age				
Y	N	Triple Negative breast cancer under age 60 (Estrogen receptor, Progesterone receptor and Her2 negative)				

Is there any other cancer in you or any family members not listed above (provide site, relationship and age):

_____

Patient's signature: _____ **Date:** _____

FOR OFFICE USE ONLY

- ☐ Patient is appropriate for further risk assessment and/or genetic testing
- ☐ Patient offered genetic testing: Accepted OR Declined
- ☐ Information given to patient to review Follow-up appointment scheduled on _____
- ☐ Patient does not have risk factors HCP Signature: _____