Udita Jahagirdar, M.D., F.A.C.O.G., P.A.

GYNECOLOGY & INFERTILITY
DIPLOMATE, AMERICAN COLLEGE OF OBSTETRICS & GYNECOLOGY

319 NORTH MANGOUSTINE AVENUE
SANFORD, FLORIDA 32771

TELEPHONE (407) 321-4560

REPLY TO
VIVOS MEDICAL CENTER
101 8TH STREET
LAKE MARY, FLORIDA 32746
TELEPHONE (407) 321-8300

We would like to welcome you to our practice and thank you for choosing Dr. Jahagirdar for your gynecological needs. In preparation for your upcoming appointment, please complete the accompanying forms and bring them with you to the appointment. We request that you not mail them in advance, and arrive 10 minutes prior to the appointment so we can process your forms at that time. Please be prepared to pay any co-pay or deductible at time of visit

In addition, please bring with you the following to your appointment:

Insurance Cards

Photo ID

REFERRAL FROM YOUR PCP (if required)

Preferred pharmacy name and phone number

List of current medication with dosages, and any over the counter medication you may be taking

List of surgical history

Any records that may be important to your visit with the Dr

Thank You

UDITA JAHAGIRDAR, M.D.

PATIENT INFORMATION

Date ____________________ Acct. No. ____________________ (leave blank)

Patient's Last Name ______________________________ First Name ______________________ M.I. ________

Billing Address ____

City ______________________________ State ____________________ Zip ____________________

Home Phone ______________________________ Work Phone ______________________________

Date of Birth ______________________________ Social Security # ______________________________

Patient Referred By ______________________________ Family Physician ______________________________

Age ____________ Marital Status: ☐ S ☐ M ☐ W ☐ D Driver's License # ______________________________

Reason for Visit ____

* *

INSURANCE INFORMATION (if applicable)

Name of Insurance Company ____

Mailing Address ____

Policy No. ______________________________ Group Name/No. ______________________________

Policyholder's Name ______________________________ Policyholder's SS # ____________________

Additional Insurance Company ____

Mailing Address ____

Policy No. ______________________________ Group Name/No. ______________________________

Policyholder's Name ______________________________ Policyholder's SS # ____________________

* *

Occupation ______________________________ Employer ______________________________

Address of Employer ____

Name of Spouse or Parent ______________________________ Phone # ____________________

Employed By: ______________________________ Phone # ____________________

* *

Alternate Contact for Emergencies: ____

Relationship ______________________________ Phone # ____________________

* *

OFFICE POLICY

- Payment/Copayment for office visit is due at the time services are rendered.
- Please be thorough with your insurance information. Give your insurance ID card and any authorization to our receptionist.
- HMO or PPO patients requiring referrals: You are responsible for making sure all visits with our office are authorized by your primary care physician (PCP) as per the policy of your insurance company.
- For labs and radiology testing: please refer to your provider handbook for contracted facility.
- If this account necessitates legal action for collection, I will be responsible for the balance due plus any legal fees and court cost.

Signature ______________________________

INSURANCE RELEASE

- I authorize any holder of medical or any other information about me to release to my insurance carriers any information needed for this or a related insurance claim.

Signature

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INFORMATION FOR YOUR PHYSICIAN

Please answer the following questions prior to your first examination.
It will help your physician to know not only about your health, but also about your family and relatives.

TODAY'S DATE

NAME | ADDRESS

TELEPHONE NUMBER | DATE OF BIRTH | AGE | PLACE OF BIRTH | RACE OR NATIONALITY OF PARENTS

RELIGION | EDUCATION (Highest level attained) | OCCUPATION ▶ | HOW LONG

PRESENT MARRIAGE (Year married) | PREVIOUS MARRIAGE (Year married and duration)

WHERE AND WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE THE U.S. AND CANADA?

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE ▶	☐		☐		☐	
DECEASED ▶	☐		☐		☐	

BROTHERS ▶	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
SISTERS ▶	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
CHILDREN ▶	NO. ALIVE	AGES & HEALTH	NO. DECEASED	AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES** ☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease
☐ Tuberculosis ☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other

CHECK ANY ILLNESSES OR CONDITIONS **YOU** HAVE HAD ☐ Diabetes ☐ Glaucoma ☐ Heart trouble ☐ Syphilis ☐ Vein trouble
☐ Cancer ☐ Asthma ☐ Jaundice ☐ Gonorrhea ☐ Bleeding tendencies ☐ Tuberculosis ☐ Pneumonia ☐ Kidney disease
☐ Rheumatic fever ☐ Nervous disorder ☐ Other

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC.?
☐ No ☐ Yes ▶ LIST:

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?
☐ No ☐ Yes ▶ LIST:

Use of street drugs? ☐ No ☐ Yes

DO YOU USE TOBACCO NOW? ☐ No ☐ Yes | IN THE PAST? ☐ No ☐ Yes | TYPE AND DAILY AMOUNT | HOW LONG?

DO YOU USE ALCOHOLIC BEVERAGES? ☐ No ☐ Yes ▶ | TYPE | WEEKLY AMOUNT | HOW LONG?

DO YOU DRINK COFFEE? ☐ No ☐ Yes ▶ | WEEKLY AMOUNT | HOW LONG?

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED
☐ Smallpox ☐ Tetanus ☐ Typhoid ☐ Polio ☐ Influenza ☐ Other

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon)

DENTAL (List any problems you have now)

MEDICATIONS (Name or otherwise identify medicines now or recently used)

ONSET DATE OF LAST MENSTRUAL PERIOD | PERIODS ARE ☐ Regular ☐ Irregular | NUMBER OF PREGNANCIES | NUMBER OF MISCARRIAGES

HAVE YOU TAKEN CORTISONE-TYPE DRUGS? ☐ No ☐ Yes | ORAL CONTRACEPTIVES? ☐ No ☐ Yes | HAVE YOU RECEIVED A BLOOD TRANSFUSION? ☐ No ☐ Yes ▶ DATE:

DRESSED WEIGHT | HOW LONG HAVE YOU BEEN AT THIS WEIGHT?

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT?

WHAT IS YOUR MAIN SYMPTOM?

REVIEWED BY (Physician) | DATE

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided

Constitutional Symptoms
- Fever Y N
- Chills Y N
- Headache Y N
- Other ______

Eyes
- Blurred vision Y N
- Double vision Y N
- Pain Y N
- Other ______

Allergic/Immunologic
- Hay Fever Y N
- Drug allergies Y N
- Other ______

Neurological
- Tremors Y N
- Dizzy spells Y N
- Numbness/tingling Y N
- Other ______

Endocrine
- Excessive thirst Y N
- Too hot/cold Y N
- Tired/sluggish Y N
- Other ______

Gastrointestinal
- Abdominal pain Y N
- Nausea/vomiting Y N
- Indigestion/heartburn Y N
- Other ______

Cardiovascular
- Chest pain Y N
- Varicose veins Y N
- High blood pressure Y N
- Other ______

Integumentary
- Skin rash Y N
- Boils Y N
- Persistent itch Y N
- Other ______

Musculoskeletal
- Joint pain Y N
- Neck pain Y N
- Back pain Y N
- Other ______

Ear/Nose/Throat/Mouth
- Ear infection Y N
- Sore throat Y N
- Sinus problems Y N
- Other ______

Genitourinary
- Urine retention Y N
- Painful urination Y N
- Urinary frequency Y N
- Other ______

Respiratory
- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N
- Other ______

Hematologic/Lymphatic
- Swollen glands Y N
- Blood clotting problem Y N
- Other ______

Psychologic
- Are you generally satisfied with your life? Y N
- Do you feel severely depressed? Y N
- Have you considered suicide? Y N
- Other ______

Physician use only: (Comments/Notes)

Physician: ______

PATIENTS NAME: ______

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FINANCIAL POLICIES FOR NO SHOWS AND CANCELLATION OF SURGERY

In order to be respectful of the medical needs of our community, please be courteous and call promptly if you are unable to attend an appointment. If it is necessary to cancel your scheduled appointment, we require that you call 24 hours prior. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

No-shows inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in your chart as a "no show"

Effective October 1, 2018 our office will be enforcing the following policies regarding no shows and surgical cancellations:

If you do not show up for your appointment without notifying us within 24 hours of your appointment time, you will be charged $25.00

If you cancel any surgical procedures without notifying us within 72 hours of your scheduled surgical procedure, you will be charged $150.00

We thank you in advance for your understanding and look forward to providing quality care

FINANCIAL POLICY

Welcome to our office. We are commited to provide you with the best possible care and to establish a mutual understanding regarding our financial policies. In order to achieve those goals, we need your assistance and your understanding of those policies.

Co-payments and/or deductibles are due at the time the service is rendered unless other arrangements have been made in advance. We accept cash, checks, Visa and MasterCard.

We will gladly discuss your proposed treatment costs and any questions you have regarding your insurance. We ask, however, that you DO NOT discuss finances with the doctor, but direct these questions to the accounts receivable department.

Your insurance is a contract between you, your employer and the insurance company. We are not a part of that contract.Not all services and supplies are a covered benefit in all contracts. We urge you to review your insurance policies

Medicare patients, we will file and accept assignment for you. Your responsibility will be your deductible and the 20% as dictated by Medicare. Our office does file secondary insurance if you have it.

Our office is on most PPO and HMO plans and will accept them gladly. You will be expected to show your insurance card at every visit. Please inform us as to which lab your insurance company uses. We will make every attempt to send your pap to the correct lab. If you do not have an insurance card, you will be responsible for the cost of that visit.

There will be a slight charge for the copying of medical records and for lengthy disability forms. There will also be a charge to your account if two or more appointments are missed without notifying our office.

We want you, our patient, to know that we will assist you in any way we can and if you have any questions regarding the above information, please do not hesitate to ask us. After reading this financial policy, please sign and return to the front desk.

Thank You,

Patients Signature
(parent if a minor)

____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Udita Jahagirdar, M.D.,P.A.'s *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Udita Jahagirdar, M.D.,P.A.may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Udita Jahagirdar, M.D.,P.A.'s *Notice of Privacy Practices* by submitting a request in writing for a current copy of Udita Jahagirdar, M.D.,P.A.'s *Notice of Privacy Practices.*

____
Printed Patient Name

____________________________________ ______________________
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

____________________________________ ______________________
Printed Patient Personal Representative Name Relationship to Patient

____________________________________ ______________________
Patient Personal Representative Signature Date

For Udita Jahagirdar, M.D.,P.A
.Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Udita Jahagirdar, M.D.,P.A.made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other______________________________________

____
Employee Name (printed)

____________________________________ ______________________
Employee Signature Date