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.

Date _____

PATIENT INFORMATION

Acct. No. _____ (leave blank)

Patient's Last Name _____ First Name _____ M.I. _____

Billing Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Social Security # _____

Patient Referred By _____ Family Physician _____

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

Reason for Visit _____

EMail Address _____

****

INSURANCE INFORMATION (if applicable)

Name of Insurance Company _____

Mailing Address _____

Policy No. _____ Group Name/No. _____

Policyholder's Name _____ DOB: _____ Policyholder's SS# _____

Additional Insurance Company _____

Mailing Address _____

Policy No. _____ Group Name/No. _____

Policyholder's Name _____ DOB: _____ Policyholder's SS# _____

****

Occupation _____ Employer _____

Address of Employer _____

Name of Spouse or Parent _____ Phone # _____

Employed By _____ Phone # _____

****

Alternate Contact for Emergencies _____

Relationship _____ Phone # _____

Please let us know what phone #s you do not wish us to contact you at _____

****

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 _____

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 ▶	☐		☐		☐	

	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
BROTHERS ▶				
SISTERS ▶				

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

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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FAX (407) 321-8820

FINANCIAL POLICY

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare will bill your secondary insurance (if any). You must provide Medicare with your secondary insurance information. They will crossover and bill your secondary insurance for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not been met. You are also responsible for any co-payments which are usually 20% of the allowed amount for an item or service.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductibles must be paid in full at the time of service. This arrangement is part of your contract with your insurance company.

SELF PAY: Payment in full is due at time of service if you do not have health insurance

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan, which may require a referral from your primary care physician prior to your appointment when visiting a specialist office. Therefore, if a referral is required and not presented at the time of your visit your appointment will be rescheduled or you will be financially responsible for services received due in full upon completion of the visit.

CLAIM SUBMISSION: As a courtesy service to you, we will submit your insurance claims for services rendered in our office and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need information from. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three statements for your financial responsibility after your insurance has processed Claims. After the third notice your account may be forwarded to a Collection Agency. If your account is assigned to an outside collection agency an additional 40% of the amount owed will added. Please let the billing department know if you have difficulties resolving your bill. Payment arrangements may be considered on a case to case basis. We accept MasterCard and Visa for your convenience.

FORM COMPLETION: There is a $10.00 per form charge for any forms you request that the doctor complete. This Fee must be paid prior to form completion.

PAYMENT POLICY: All balances will be due in full at the time of your office visit whether or not you have received a statement from our office. We will provide you with a copy of your bill and the insurance credits upon request.

There is a $35.00 charge for checks returned unpaid by your bank
We reserve the right to charge $25.00 fee for missed appointments and $150.00 charge for surgical appointments.

If you are unable to make your appointment please cancel/reschedule at least 72 hours in advance.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and/or Contact information. I understand and accept these terms.

PRINT Patients Name: _____ Signature: _____

PRINT Responsible Party's Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

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