

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 _____ 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 _____

E-Mail 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?

ALIVE ▶ DECEASED ▶	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
BROTHERS ▶						
	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
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 Gonorrhoea 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:

DO YOU USE TOBACCO NOW?		IN THE PAST?	TYPE AND DAILY AMOUNT		Use of street drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes				HOW LONG?
DO YOU USE ALCOHOLIC BEVERAGES?		TYPE		WEEKLY AMOUNT	HOW LONG?
<input type="checkbox"/> No <input type="checkbox"/> Yes ▶					
DO YOU DRINK COFFEE?				WEEKLY AMOUNT	HOW LONG?
<input type="checkbox"/> No <input type="checkbox"/> Yes ▶					

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 <input type="checkbox"/> Regular <input type="checkbox"/> Irregular	NUMBER OF PREGNANCIES	NUMBER OF MISCARRIAGES
HAVE YOU TAKEN CORTISONE-TYPE DRUGS? <input type="checkbox"/> No <input type="checkbox"/> Yes	ORAL CONTRACEPTIVES? <input type="checkbox"/> No <input type="checkbox"/> Yes	HAVE YOU RECEIVED A BLOOD TRANSFUSION? <input type="checkbox"/> No <input type="checkbox"/> 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: _____

PELVIC EXAMINATIONS CONSENT FORM

Patient Name: _____

Date of Birth: _____

• **CONSENT:** I, the above listed Patient or as the legally authorized person for the Patient, hereby consent to receiving pelvic examinations being performed by my physician.

• **NATURE OF PELVIC EXAMINATIONS:**

For the purposes of this Consent Form, a "pelvic examination" on a female means the series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

For purposes of the Consent Form, a "pelvic examination" on a male means examination of the rectum, prostate, and external tissue or organs, including the penis or scrotum using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

I CONSENT TO RECEIVE PELVIC EXAMINATIONS AS DESCRIBED ABOVE, AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

Patient's Signature

Date

Legally Authorized Person Signature

Relationship to Patient

Legally Authorized Person Printed Name

Date

Witness Signature

Witness Printed Name

Date

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FAX (407) 330-1298

"VIVOS", 101 N.8TH STREET
LAKE MARY, FLORIDA 32746
TELEPHONE (407) 321-8300
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