Genesis OBGYN
Jennifer W. Seaton, M.D.
REGISTRATION FORM

Today's date: | PCP:

PATIENT INFORMATION

Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F

Street address: | Social Security no.: - - | Home phone no.: Message Ok? ❑ Yes ❑ No ( )

City: | State: | ZIP Code: | Cell phone Message Ok? ❑ Yes ❑ No ( )

Occupation: | Employer: | Employer phone no.: Message Ok? ❑ Yes ❑ No ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

INSURANCE INFORMATION

Please indicate primary insurance

Policy No: | Group no.:

Subscriber's name: (if different) | Subscriber's S.S. no.: - - | Birth date: / /

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Address (if different): | Home phone no.: Message Ok? ❑ Yes ❑ No ( )

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information in relation to all claims, including Medicare for benefits submitted on my behalf and/or my dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each claim form to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed each claim. I hereby authorize my insurance carrier to pay and assign all medical and/or surgery benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Jennifer W. Seaton, M.D. I authorize the release of any medical records requested by my Insurance carrier or the Health Care Financing Administration needed to determine benefits or the benefits payable for related services. INSURANCE COVERAGE IS NOT A GUARANTEE OF PAYMENT FOR ANY CLAIM, FURTHER I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED REGARDLESS OF INSURANCE COVERAGE.

Patient/Guardian signature | *Date*

Date:	Reviewed by:

GENESIS OBGYN

Jennifer W. Seaton, M.D.

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	DOB:	SSN:

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

List any medical problems that other doctors have diagnosed

SURGERIES

Year	Reason	Hospital

PAST MEDICAL HISTORY

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken	How Long?

Allergies to medications		**Allergies to food / other**	
Name the Drug	Describe Reaction	Please List	Describe Reaction

Date:	Reviewed by:	
Name *(Last, First, M.I.):*	DOB:	SSN:

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?				☐ Yes	☐ No
	Would you like information on the preparation of these?				☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

Date:	Reviewed by:	
Name *(Last, First, M.I.):*	DOB:	SSN:

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Please if any family member has any of the following illnesses / provide which relative (i.e., father, mother, uncle, sister, etc.)

High Blood Pressure?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No
Heart Disease?	☐ Yes	☐ No
Tuberculosis?	☐ Yes	☐ No
Stroke?	☐ Yes	☐ No
Epilepsy?	☐ Yes	☐ No
Mental Illness?	☐ Yes	☐ No
Cancer?	☐ Yes	☐ No
Type of Cancer (i.e. breast, ovarian cervical, lung, etc)		
Other? (please provide illness)		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

PREVENTION

First day of last menstrual period:	Last Pap Smear?		Result?
Have you ever had an abnormal pap smear? ☐Yes ☐No	When?		
Have you had a hysterectomy? ☐Yes ☐No	When?		Both ovaries removed? ☐Yes ☐No
Are you currently taking Hormone replacement therapy (HRT)? ☐Yes ☐No	Have you ever taken HRT? ☐Yes ☐No		How Long?
Have you ever had a DEXA scan? (bone density) ☐Yes ☐No	Date of last exam?		Result?
Date of last Colon exam? Result? _____	Date of last Cholesterol Screen? Result? _____		Date of last Chest X – Ray? Result? _____

Date: | Reviewed by:

Name *(Last, First, M.I.):* | DOB: | SSN:

CONTRACEPTION

Are you using any birth control? ☐Yes ☐No | What Type? | How Long?

Do you want information about birth control? ☐Yes ☐No | What types?

What types of Birth control have you used in the past? (if any)

Do you desire to get pregnant in the near future? ☐Yes ☐No | Have you been unable to conceive within the past year? ☐Yes ☐No

URINARY

Urinate frequently? ☐Yes ☐No times per hour?___

Painful Urination? ☐Yes ☐No

Blood in urine? ☐Yes ☐No

Urinary tract infections? ☐Yes ☐No # in past year? ____

Hurry to Bathroom to avoid urine loss? ☐Yes ☐No

Kidney Stones? ☐Yes ☐No When? _____

Pelvic pressure? ☐Yes ☐No

Uncontrollable loss of large volumes? ☐Yes ☐No

Wake up more than once a night to urinate? ☐Yes ☐No

Urine leakage with cough, sneeze or laugh? ☐Yes ☐No

BREAST

Do you perform monthly self breast exam? ☐Yes ☐No

Breast Pain? ☐Yes ☐No Describe:_____

Breast Lumps? ☐Yes ☐No Where? _____

Nipple Discharge? ☐Yes ☐No Color? _____ Which Breast? _____

Family History of Breast Cancer? ☐Yes ☐No If yes who? _____

Last Mammogram: _____ Result: _____

Ever had an abnormal Mammogram? ☐Yes ☐No When? _____

Ever had a breast biopsy? ☐Yes ☐No When? _____

REPRODUCTIVE

Significant change in periods? ☐Yes ☐No | Infrequent? | How often?

Irregular? | How long? | Painful Periods? ☐Yes ☐No | Heavy Periods? ☐Yes ☐No

Have you had any vaginal discharge? ☐Yes ☐No | Describe: _____ | Have you had a vaginal infection? ☐Yes ☐No | What type? _____

At what age were you menopausal? | Have you experienced Hot Flashes? ☐Yes ☐No | Did you have vaginal bleeding after menopause? ☐Yes ☐No

Have you experienced: | Vaginal dryness? ☐Yes ☐No | Feminine Itching? ☐Yes ☐No | Pain with intercourse? ☐Yes ☐No | Decreased or absent sexual drive? ☐Yes ☐No

OBSTETRICAL HISTORY

Number of pregnancies | Number of live births

Are you currently pregnant? ☐Yes ☐No | Are you currently breastfeeding? ☐Yes ☐No

DELIVERY HISTORY

Year	Weeks Gestation	Type of Delivery (vaginal or cesarean)	Place of Birth / Hospital	Birth Weight	Complications

MISCARRIAGES

Year	Weeks Gestation				

Date:	Reviewed by:	
Name *(Last, First, M.I.):*	DOB:	SSN:

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas ☐Now ☐Past ☐Never

General:	Weight Change: ☐Now ☐Past ☐Never	Fatigue: ☐Now ☐Past ☐Never	Night Sweats: ☐Now ☐Past ☐Never	Fever: ☐Now ☐Past ☐Never	Chills: ☐Now ☐Past ☐Never	Malaise: ☐Now ☐Past ☐Never
Skin:	Dryness: ☐Now ☐Past ☐Never	Itching: ☐Now ☐Past ☐Never	Rash: ☐Now ☐Past ☐Never	Acne: ☐Now ☐Past ☐Never	Ulcers: ☐Now ☐Past ☐Never	Suspicious lesion/mole: ☐Now ☐Past ☐Never
Eyes:	Blurred Vision: ☐Now ☐Past ☐Never	Vision Changes: ☐Now ☐Past ☐Never	Glasses/Contacts: ☐Now ☐Past ☐Never	Glaucoma: ☐Now ☐Past ☐Never	Eye Irritation: ☐Now ☐Past ☐Never	Eye Pain: ☐Now ☐Past ☐Never
Ears:	Decreased Hearing: ☐Now ☐Past ☐Never	Difficulty Hearing: ☐Now ☐Past ☐Never	Ringing in Ears: ☐Now ☐Past ☐Never	Ear Pain: ☐Now ☐Past ☐Never		
Nose:	Nose Bleeds: ☐Now ☐Past ☐Never	Seasonal Allergies: ☐Now ☐Past ☐Never	Sinus Infections: ☐Now ☐Past ☐Never			
Throat/Mouth:	Hoarseness: ☐Now ☐Past ☐Never	Pain with Swallowing: ☐Now ☐Past ☐Never	Bleeding Gums: ☐Now ☐Past ☐Never	Mouth Ulcers: ☐Now ☐Past ☐Never	Cavities: ☐Now ☐Past ☐Never	
Respiratory:	Shortness of Breath: ☐Now ☐Past ☐Never	Persistent cough: ☐Now ☐Past ☐Never	Easily Fatigued: ☐Now ☐Past ☐Never	Wheezing: ☐Now ☐Past ☐Never	Cigarette Smoking: ☐Now ☐Past ☐Never	Bloody Sputum: ☐Now ☐Past ☐Never
Cardiovascular:	Chest Pain: ☐Now ☐Past ☐Never	Heart Palpitations: ☐Now ☐Past ☐Never	Heart Murmur: ☐Now ☐Past ☐Never	Peripheral Edema (swelling of extremities): ☐Now ☐Past ☐Never	Blood Pressure: ☐High ☐Low ☐Normal	
Musculoskeletal:	Back Pain: ☐Now ☐Past ☐Never	Joint Pain: ☐Now ☐Past ☐Never	Muscle Weakness: ☐Now ☐Past ☐Never	Joint Swelling: ☐Now ☐Past ☐Never		
Gastrointestinal:	Change in appetite ☐Now ☐Past ☐Never	Nausea/vomiting: ☐Now ☐Past ☐Never	Heartburn or Indigestion: ☐Now ☐Past ☐Never	Diarrhea: ☐Now ☐Past ☐Never	Constipation: ☐Now ☐Past ☐Never	
Gastrointestinal cont:	Abdominal Pain: ☐Now ☐Past ☐Never	Change in bowel habits: ☐Now ☐Past ☐Never	Black or bloody bowel movements: ☐Now ☐Past ☐Never	Hemorrhoids: ☐Now ☐Past ☐Never	Loss of bowel control: ☐Now ☐Past ☐Never	
Genitourinary:	Painful Urination: ☐Now ☐Past ☐Never	Hesitancy: ☐Now ☐Past ☐Never	Blood in Urine: ☐Now ☐Past ☐Never	Urinary Incontinence: ☐Now ☐Past ☐Never	Sexual Dysfunction: ☐Now ☐Past ☐Never	
Neurological:	Dizziness: ☐Now ☐Past ☐Never	Seizures: ☐Now ☐Past ☐Never	Stroke: ☐Now ☐Past ☐Never	Headaches: Frequency? _____ ☐Now ☐Past ☐Never	Memory Loss: ☐Now ☐Past ☐Never	
Psychiatric:	Dizziness: ☐Now ☐Past ☐Never	Tension/Stress: ☐Now ☐Past ☐Never	Insomnia: ☐Now ☐Past ☐Never	Restless Dreams: ☐Now ☐Past ☐Never	Hallucinations: ☐Now ☐Past ☐Never	Anxiety / Depression: ☐Now ☐Past ☐Never
Endocrine:	(circle one) Cold/Heat Intolerance: ☐Now ☐Past ☐Never	Diabetes: ☐Now ☐Past ☐Never	Thyroid Disorder: ☐Now ☐Past ☐Never	Hair Falling Out: ☐Now ☐Past ☐Never	Weight Change: ☐Now ☐Past ☐Never	
Hematologic / Lymphatic:	Anemia: ☐Now ☐Past ☐Never	Easy Bleeding: ☐Now ☐Past ☐Never	Abnormal Bruising: ☐Now ☐Past ☐Never	Enlarged Glands: ☐Now ☐Past ☐Never	Blood Clots in legs: ☐Now ☐Past ☐Never	Blood Transfusion: Year?
Allergic / Immunologic	Hay Fever: ☐Now ☐Past ☐Never	Itching: ☐Now ☐Past ☐Never	HIV Exposure: ☐Now ☐Past ☐Never			

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed
The information covered by this authorization includes:
All health information for the patient listed below

Purposes of Disclosure
Information listed above will be disclosed for the following purposes:
Continuous treatment of patient and billing purposes

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:
Genesis OBGYN/ Dr. Jennifer Seaton and Business Associates
Name of person/organization

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:
Genesis OB/GYN
Name of person/organization

Expiration Date of Authorization
This authorization is effective through ___/___/___ unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to **Genesis OBGYN** at (850) 362-6435

Rights of the Individual
- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization.

_____
Name of Patient (Print or Type)

_____
Signature of Patient Date

_____
Signature of Patient Representative
Relationship of Patient Representative to Patient

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_____
Signature of Patient Date

_____
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Relationship of Patient Representative to Patient

Notice of Privacy Practices
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures
Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **[Name of Practice]**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Genesis OBGYN Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **Genesis OBGYN**. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Genesis OBGYN
915 Mar Walt Drive
Fort Walton Beach, FL 32547

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint

Acknowledgment of Receipt of Notice of Privacy Practices

Jennifer Seaton, M.D. reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notice of Privacy Practices for **Genesis OBGYN**.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

_____
Relationship of Patient Representative to Patient