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*
(Check One) ☐ Employed ☐ Retired ☐ Full-Time Student
*Marque Uno* *Empleada* *Retirada* *Estudiante Tiempo Completo*
☐ Other ______________________
*Otro*
Employer ______________________
*Empleador*
Work Phone (______) ______________________
*Telefono del 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*

## 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 ____/____/____
*Sex* *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 mire al Dorso*

## FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos ciertas tajetas de credito. Su seguro medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to S.458.320 (5)(g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida law.

Hemos elegido no llevar seguro de negligencia medica o no demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cuaquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (la ley 5) (g). Florida impone penas contra los medicos de los no-asegurado que no pueden satisfacer los juicios adversos que se presentan de demandas de la negligencia medica. Este aviso esta conforme a la ley de la Florida.

## PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by the physician. I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a el medico todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsible por todos los cargos no cubiertos bajo mi seguro medico.

PATIENT'S / GUARANTOR'S SIGNATURE ____________________ DATE ____________

GIL ARONSON, M.D., FACOG

OBSTETRICS ■ GYNECOLOGY ■ INFERTILITY

**PATIENT'S HISTORY SHEET**

DO YOU HAVE AN **ALLERGY** TO ANY MEDICATION? Y / N
***IF YES, PLEASE LIST:____________________
DO YOU DRINK ALCOHOLIC BEVERAGES REGULARLY? Y / N
DO YOU SMOKE? Y / N
WHAT DO YOU USE FOR CONTRACEPTION:____________________

**GYNECOLOGIC HISTORY:**

HAVE YOU EVER HAD AN ***ABNORMAL*** PAP SMEAR? Y / N
ARE YOUR PERIODS EVER ***NOT*** REGULAR? Y / N
ARE YOUR PERIODS VERY PAINFUL? Y / N
DO YOU HAVE PELVIC PAIN OTHER THAN YOUR PERIOD? Y / N
IS YOUR PERIOD LONGER THAN 5 DAYS? Y / N
DO YOU HAVE VAGINAL BLEEDING IN BETWEEN PERIODS? Y / N
DO YOU HAVE AN ABNORMAL VAGINAL DISCHARGE? Y / N
DO YOU HAVE ANY BLEEDING WITH SEXUAL INTERCOURSE? Y / N
DO YOU HAVE ANY PAIN DURING INTERCOURSE? Y / N
DO YOU LOOSE ANY URINE WHEN COUGHING/SNEEZING? Y / N
HAVE YOU EVER HAD AN INFECTION OF YOUR TUBES / OVARIES? Y / N

HAVE YOU EVER HAD GYNECOLOGIC SURGERY? Y / N
HAVE YOU EVER BEEN DIAGNOSED WITH A SEXUALLY TRANSMITTED DISEASE? Y / N

**OBSTETRIC HISTORY:**

HAVE YOU EVER HAD A MISCARRIAGE? Y / N
HAVE YOU EVER HAD AN ABORTION? Y / N
HAVE YOU EVER HAD AN ECTOPIC PREGNANCY? Y / N
DO YOU HAVE ANY CHILDREN? Y / N

| NAME | AGE | BIRTH WT. | VAGINAL / C-SECTION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

1150 N. 35th AVENUE ■ SUITE 385 ■ HOLLYWOOD, FL ■ 33021-5429 ■ PHONE: (954) 963-7080 ■ FAX: (954) 966-2990
2229 N. COMMERCE PARKWAY ■ SUITE 200 ■ WESTON, FLORIDA 33326-3239 ■ PHONE: (954) 389-0000 ■ FAX: (954) 389-7778

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**MEDICAL HISTORY:** CIRCLE IF ***YOU*** HAVE ANY OF THE FOLLOWING:

DIABETES HYPERTENSION THYROID DISEASE AUTO-IMMUNE DISEASE

ASTHMA ANEMIA CLOTTING PROBLEMS DEEP VENOUS THROMBOSIS

CANCER HEART DISEASE KIDNEY DISEASE NEUROLOGICAL DISEASE

ULCERS BOWEL DISEASE LIVER DISEASE ARTHRITIS MIGRAINES

PSYCHIATRIC PROBLEMS DRUG / ALCOHOL ABUSE

ANY OTHER MEDICAL CONDITION WE SHOULD KNOW?____________________

**SURGICAL HISTORY:** IF ANY OPERATIONS, PLEASE LIST BELOW

____________________________________________________

____________________________________________________

DO YOU HAVE A FAMILY HISTORY OF BREAST CANCER? Y / N
DO YOU HAVE A FAMILY HISTORY OF OVARIAN CANCER? Y / N

**LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:**

____________________________________________________

____________________________________________________

HAVE YOU PREPARED AN ADVANCED DIRECTIVE? Y / N
HAVE YOU PREPARED A LIVING WILL? Y / N

**PATIENT NAME:** ____________________ **PATIENT SIGNATURE:** ____________________

**DATE:** ____________________


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GIL ARONSON, M.D., FACOG

OBSTETRICS GYNECOLOGY INFERTILITY

I have read and understand the Notice of Privacy Practices of **Dr. Gil Aronson.** I understand how medical information about me may be used and disclosed and how I can get access to this information.

**Name**________________________

**Date**__________________________

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