THE WOMEN'S WELLNESS CTR OF SO FL, LLC

PATIENT INFORMATION UPDATE

COPIES OF DRIVER'S LICENCE INSURANCE CARD(S) REQUIRED

PATIENT'S NAME_____

STREET ADDRESS_____Apt #_____

CITY_____STATE_____ ZIP CODE_____

HOME PHONE_____SS#_____

WORK PHONE_____DATE OF BIRTH_____

PHARMACY PHONE: _____PRIMARY CARE MD:_____

***EMAIL ADDRESS _____

CELL PHONE #_____ CELL PHONE CO _____

OCCUPATION_____EMPLOYER_____

MARITAL STATUS: Single ____ Married ____ Divorced ____ Widowed _____

SPOUSE'S NAME_____SS#_____

BIRTH DATE_____ EMPLOYER_____

_____

NAME OF INSURANCE CO._____INS#_____

ADDRESS_____INS PHONE#_____

CONTACT IN CASE OF
EMERGENCY? _____PHONE#_____

I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE OFFICE OF ANY CHANGES TO THE ABOVE INFORMATION OR TO MY HEALTH STATUS.

PATIENT'S SIGNATURE_____DATE_____

The Womens Wellness Center of South Florida, L.L.C.

PATIENT INTAKE QUESTIONNAIRE

Chief Complaint: _____

Duration of symptoms: _____

Medical Problems:

_____Allergies to Antibiotics: _____

_____Anemia

_____Asthma

_____Cancer

_____Depression

_____Diabetes

_____Endometriosis

_____Gastric Reflux

_____Heart Disease

_____High Blood Pressure

_____Hepatitis

_____Hypothyroidism

_____Kidney Disease.

_____Liver Disease

_____Neurological Disorders

_____Ulcers

_____Family History_____

_____Other_____

Surgeries:

_____

_____

Patient Signature Date

Patient Contact Form

Date_____

Name of patient_____

All calls regarding your care, test results, and appointments will be made to your home telephone number. If you would like us to contact you at an alternate telephone number, please indicate that telephone number here: (_____)_____

_____ I hereby authorize this medical practice to contact me by telephone and if I am not present, they may leave a message on my answering machine.

_____ Do *NOT* leave messages on answering machine other than name of caller and telephone number.

Other Contact Information

The following people other than a duly designated guardian or conservator are authorized to discuss my medical condition or billing information with a healthcare professional in this practice:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Patient Signature_____ Date_____
Print Name _____
Telephone Number_____

.....

For office Use Only
Signed form received by (Please Print)
_____ Date _____

The Women's Wellness Center of South Florida, LLC
Tara A. Solomon, M.D.

3850 Coconut Creek Pkwy Suite One
Coconut Creek, FL 33066
Phone: 954-984-8892 / Fax: 954-984-8810

I, _____ HAVE READ THE NOTICE OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT PROVIDED TO ME BY DR. TARA SOLOMON. I UNDERSTAND THAT IF I FEEL THAT MY PRIVACY RIGHTS HAVE BEEN VIOLATED, I MAY FILE A COMPLAINT WITH DR. TARA SOLOMON OR WITH THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

ALL OF MY QUESTIONS HAVE BEEN ANSWERED.

_____ _____

PATIENT **DATE**

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Tara A. Solomon, M.D.

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AUTHORIZATION & RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payors and/or other health practitioners.
I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Patient_____Dated_____
(Guardian's signature for patients under the age of 18)

******If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed may be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on the amount of any future outstanding account balances.**

The Women's Wellness Ctr of South Florida, LLC

List of Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

List of Vitamins

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____