Donald W. Whitaker, M.D., PA

924 Mar Walt Drive
Phone: (850) 863-1000 Fort Walton Beach, FL 32547 Fax (850) 863-0800

APPT. MADE _____ NEW GYN _____ NEW OB _____ LMP _____

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

First: _____ M.I.: ____ Last Name: _____

Address: _____ Social Security Number: ____/____/____

City: _____ State: _____ Zip: _____ Date of Birth: ____/____/____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Race (circle one): Asian, Black or African American, Native Hawaiian/Pacific Islander, White, Other

Ethnicity - Hispanic / Latino: YES NO UNKNOWN

Language: _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

H Phone: _____ W Phone: _____ Cell: _____ Day: H W C Mess ok?: Y N

Email address: _____

Emergency Contact Name: _____ Phone: (____) _____

Who is your Primary Care Physician? _____ **Last Visit?** _____

PRIMARY INSURANCE INFORMATION: *This information is required*

Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Employer ( ) Other: _____

Insurance Company: _____ **Name of Insured:** _____

Insured's Date of Birth: ____/____/____ **Social Security Number:** ____/____/____ Sex: ( ) M ( ) F

Insured's Address (if different from patient's): _____ Phone: (____) _____

Employer: _____ Address: _____ Phone: (____) _____

Insured's ID Number: _____ **Group Policy Number:** _____

Secondary Insurance Coverage:

Insurance Company: _____ Name of Insured: _____

Insured's Date of Birth: ____/____/____ Insured's ID Number: _____ Insured's SSN: ____/____/____

Address: _____ Effective Date: _____

Tricare for Life: Effective Date: _____ Expiration Date: _____

Sponsor's Date of Birth: ____/____/____ Sponsor's SSN: ____/____/____ Service/Rank: _____ Status: _____

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 Donald Whitaker, MD and/or Donald W. Whitaker M.D., P.A. 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.**

Authorized Signature: _____ **Date:** _____

Date Information Updated: _____ **Initials:** _____

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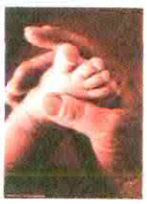

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Phone (850) 863-1000 *Fax (850) 863-0800*

Name: _____ Age: _____ Date of Birth: _____

Last Physical: _____ *Referred By:* _____

Reason for seeking medical help: _____

_____

_____

MEDICATIONS

List all current medications you are currently taking INCLUDING aspirin, non-prescription, vitamins and herbs.

Name	Dosage	Times per day	How long?

ALLERGIES

Name of Medication	Type of Reaction

Past Medical History:

( ) Y ( ) N Do you have a history of STD infections?

( ) Y ( ) N Have you experienced menopause? If yes, at what age? _____

Have you been diagnosed with any of the following illnesses? (please circle all that apply)

Aids / HIV
Anemia
Arthritis
Asthma
Bladder Problems
Blood Clots in Legs
Blood / Plasma Transfusions
Bowel Problems
Cancer
Chickenpox
Diabetes
Digestion Problems
Epilepsy
Heart Disease
Hepatitis
High / Low Blood Pressure
Kidney Stones
Liver Disease
Migraine Headaches
Pneumonia
Prolonged Bleeding
Psychological Problems
Stroke
Thyroid Disease
Varicose Veins

Have you ever had surgery or been hospitalized? ( ) Yes ( ) No

Year	Type of Surgery / Reason for hospitalization

Prevention:

( ) Y ( ) N Hysterectomy? If yes, why? _____

( ) Y ( ) N Were both ovaries removed?

( ) Y ( ) N Have you ever had an abnormal pap smear? If yes, abnormal findings? _____

( ) Y ( ) N Do you consistently wear a seat belt?

Date of last Flu shot: _____ Date of last Pneumonia shot: _____

Breast:

( ) Y ( ) N Ever had a previous breast biopsy? If yes, results? _____

Contraception:

( ) Y ( ) N Are you using any birth control? If yes, type: _____

Date of last menstrual period: _____

OBSTETRICS HISTORY

Do you have children? YES NO How many? _____

Year	Weeks Gestation	Type of Delivery (Vaginal or Cesarean)	Birth Weight	Complications

MISCARRIAGES

Year	Weeks	Known Cause	D & C done?	Complications

Family Medical History

( ) Y ( ) N Is there a family history of breast or ovarian cancer? Mother Maternal Grandmother Paternal Grandmother
Sister Maternal Aunt Paternal Aunt

Has any member of your family had any of the following:

( ) Y ( ) N Arthritis? Who? _____ ( ) Y ( ) N Hypertension? Who? _____
( ) Y ( ) N Cancer? Who? _____ ( ) Y ( ) N Mental Illness? Who? _____
( ) Y ( ) N Circulatory Disease? Who? _____ ( ) Y ( ) N Neurological problems? Who? _____
( ) Y ( ) N Diabetes? Who? _____ ( ) Y ( ) N Phlebitis? Who? _____
( ) Y ( ) N Epilepsy? Who? _____ ( ) Y ( ) N Skin Disease? Who? _____
( ) Y ( ) N Foot Problems? Who? _____ ( ) Y ( ) N Stroke? Who? _____
( ) Y ( ) N Heart Disease? Who? _____ ( ) Y ( ) N Tuberculosis? Who? _____

Other family history: _____

Social History:

Current occupation: _____ Circle one: Sits at job Stands at job
Stands and walks at job Retired / Unemployed

( ) Y ( ) N Do you drink alcohol? How often? (circle one) Daily Weekly Monthly Seldom Occasionally
( ) Y ( ) N Do you drink coffee / tea / soda? (circle one) How many cups per day? _____
( ) Y ( ) N Do you use recreational drugs? Type(s) _____

Tobacco use:

( ) Current every day smoker When started? _____ Number of packs / day? _____
( ) Current some days smoker When started? _____
( ) Former smoker Total number of years? _____
( ) Never smoker

( ) Y ( ) N Do you exercise? Type of exercise? _____
How often? (circle one) once a week twice a week three times a week
every day occasionally

I hereby authorize Donald W. Whitaker, M.D., P.A. to treat me for any of the aforementioned problem(s) identified and understand that this will be explained to me

Patient's Signature: _____ **Date**: _____

Office of Donald W. Whitaker, MD
NOTICE OF PRIVACY PRACTICES

Effective Date: 04/14/2003

Updated 09/23/2013

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.

Each time you visit a physician, hospital, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. Your record represents Protected Health Information.

We are *committed* to treating and using Protected Health Information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice applies to all Protected Health Information, as defined by federal regulations, which is generated by our office.

THE FOLLOWING CATEGORIES DESCRIBE EXAMPLES OF THE WAYS WE USE AND DISCLOSE HEALTH INFORMATION

For Treatment: We may use your health information to provide you with medical treatment or services. We may disclose medical information about you to other health professionals who contribute to your care (such as doctors, nurses, technicians, or other personnel who are involved in taking care of you).

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment form you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your treatment so they will pay us for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it, unless you exercise your right to restrict**

For Healthcare Operations (Business Associates): There are some services provided in our office through contracts with business associates. Examples include transcription of your dictated health information, a copy service making copies of your health records, e-Prescribing service, a person who provides data transmission services, computer software vendor, and subcontractors that create, receive, maintain or transmit your medical information on behalf of the contracted Business Associate as required by Omnibus HIPAA Rule compliance. When services such as these are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information as required by HIPAA regulations.

Communication with Family or Friend: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

For Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

For Research, Marketing, Fundraising: Our office does not sell your protected health information. Any activity for research, marketing, fundraising requires your written authorization.

We may also use and disclose medical information to / for the following:

*to remind you that you have an appointment
*to assess your satisfaction with our services
*Food and Drug Administration
*Organ and Tissue Donation Organizations
*Health Oversight Agencies
*Funeral Directors, Coroners, Medical Directors
*Protective Services for the President of the United States
*Public Health Authorities
*Workers Compensation Agents
*Legal Authorities
*Military Command Authorities
*National Security & Intelligence
*to notify or assist in notifying a disaster relief entity so that your family can be notified about your health status
*for law enforcement purposes as required by law or in response to subpoena

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of this office, you have the right to:

Inspect and Copy: You have the right to view your Protected Health Information, obtain a copy of the information, or both. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We are allowed to charge you for these copies. If capabilities exist, you may request access to your medical records in electronic format.

Amend: If you feel that medical information is incorrect or incomplete, you may ask us to amend (not change) the information. We may deny your request for an amendment; and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request a list of certain disclosures we make of your medical information for purposes other than treatment, payment, or healthcare operations.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree to the requested restriction, it will be honored with the exception of permitted disclosures, including emergency treatment, public health authority, Food & Drug Administration, work-related injury, and OSHA compliance.

**Restricted Disclosure: You have the right to restrict disclosure of your personal protected health information to your health plan/insurance company if that information pertains solely to healthcare for which you (or a person on your behalf) paid for the testing or treatment in full, out of pocket. You must continue to pay out of pocket for subsequent care related to restricted disclosure.

Genetic Information: Your genetic information is treated as Protected Health Information. It cannot be used to discriminate against you for the provision of health insurance or for underwriting purposes.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location (for example, at work, or by U.S. Mail). We will grant this request only if it is submitted in writing. We reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.

Breach: You will be notified within sixty days if a reportable breach of your protected health information occurs.

A Paper Copy of This Notice: You may ask us to give you a copy of the Notice.

If you have any questions about this Notice, please contact our Privacy Officer at this office, telephone: 850-863-1000

We reserve the right to change this notice and to make the new provisions effective for all Protected Health Information we maintain from the first date of your health record. The current notice will be posted and include the effective date.

If you believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer in our office at : 924 Mar Walt Drive., Ft. Walton Beach, FL 32547.
All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You may revoke your permission to use or disclose medical information about you, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgment of Receipt of Notice of Privacy Practices
Office of Donald W. Whitaker, MD

By signing this document, I acknowledge that I have read a copy of this office's Notice of Privacy Practices.

PRINT Name _____ Signature _____ Date _____

Office Use Only: Date Acknowledgement received _____ by _____
OR reason Acknowledgment was not obtained _____

Source: ECHA