UFirstHealth
Surgery • Gynecology • Medi-Spa
12640 World Plaza Lane, Building #71
Fort Myers, FL 33907
Phone: 239.243.8222 Fax: 239.206.4779

REGISTRATION FORM (Please Print)

Today's Date:

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle Initial:**	**Marital status:** Single ❑ Mar ❑ Div ❑ Sep ❑ Wid ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑
Mother's Name:	**Father's Name:**	**Parents Contact**	**Name of Spouse and Contact Number:**

Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**	**Home Phone No.:** ( )	**Birth date:**	**Age:**	**Sex:** ❑M ❑F
Street address:	**City, State and Zip Code:**		**Social Security No.:**		
Mailing Address:	**City:**		**State:**	**Zip:**	
Occupation:	**Employer:**		**Employer phone no.:** ( )		
What is your preferred method of contacting you, email, home or cell phone?	❑ Email @ ❑Home phone ( ) -		❑Cell phone:( ) - ❑Regular mail		
Referred to UFirst Health by (check one box):	❑ Dr	❑ Yellow Pages	❑ Insurance plan ❑ Hospital CCH or GCH		
❑ Family	❑ Friend	❑Health & Wellness Magazine	❑Internet		
Other family members seen here:					
Primary Care Physician: Dr.	**Phone: ( )**		**Fax: ( )**		
Street address:	**City:**	**State:**	**Zip:**		

INSURANCE INFORMATION

(Please give your insurance card and picture ID to the receptionist.)

Is this patient covered by insurance?	❑ Yes	❑ No			
Please Indicate primary insurance	❑ Self Pay (Includes Medi-Spa Patients)			❑ Medicaid	
❑PPO ❑HMO	❑Other		❑Medicare		
Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:**	**Group no.:**	**Policy no.:**	**Co•payment:** $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	**Subscriber's name:**		**Date of birth:**	**Policy no.:**	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative:	**Relationship to patient:**	**Home phone no.:** ( )	**Work phone no.:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize U First Health to release any information required to process my claims.

Patent/Guardian signature	***Date***

Health Historv

NEED ASSISTANCE TO COMPLETE? ❑No ❑Yes

Name: Today's Date:
Marital Status: S M D W Gender: M F Age: Date Of Birth:
Education: Occupation:
Name Of Your Previous/Current Physician/Provider:
Current Concerns:

DRUG ALLERGIES & TYPE OF REACTION

FAMILY HISTORY

Checkmark Family Members With These Conditions:	Father/deceased?age?	Mother/deceased?age?	Father's Parents	Mother's Parents	Siblings	Children	Other
Heart Disease							
High Blood Pressure							
Migraine Headaches							
Stroke							
Glaucoma							
Diabetes							
Epilepsy/Seizures							
High Cholesterol							
Bleeding Disorder							
Kidney/Liver Disease							
Asthma							
Thyroid Disease							
Cancer (what type)							
Drugs/Alcoholism							
Mental Illnesses							

CURRENT PRESCRIPTION AND OTC MEDICATIONS

Medication	Dose	How often?	Medication	Dose	How often?

HOSPITALIZATION OR SURGERY

REASON	DATE	REASON	DATE

PAST MEDICAL HISTORY (SPECIFY DIAGNOSIS FOR EACH PROBLEM IF KNOWN)

❑Headache	❑Gall Bladder Disease	❑Glaucoma	❑Shortness of Breath
❑Prostate Disease	❑Rheumatic Fever	❑Heart Attack or Angina	❑Rectal Bleeding
❑Kidney Stones	❑Heart Murmur	❑Menstrual Dysfunction	❑Seizures or Convulsions
❑Chest Pain	❑Sexually Transmitted Disease	❑High Cholesterol	❑Fainting
❑Frequent Infections	❑HIV/AIDS	❑Peripheral Vascular Disease	❑Hepatitis
❑Diabetes	❑Allergies or Hay Fever	❑Anemia	❑Inflammatory Bowel Syndrome
❑Asthma	❑Arthritis	❑Alcoholism	❑Chronic Bronchitis/Emphysema
❑Nervousness or Anxiety	❑Drug Dependency	❑Pneumonia	❑Depression
❑Cancer or Tumor (Type?)	❑Goiter or Thyroid Problems	❑Gout	❑Crohn's Disease
❑Ulcer/GI Disorder	❑High Blood Pressure	❑Other (specify)	❑ Other (specify)

HABITS AND SOCIAL HISTORY

❑Tobacco: Type & Amount Used? If Quit, When?
❑Alcohol: Type & Amount Used? Frequency Of Drinking?
❑Drugs: Type & Amount Used? Frequency Of Use?
❑Caffeine: Type & Amount Used? Frequency Of Use?
❑Exercise: Type & Frequency? ****Date Of Last Tetanus Booster?**

FOR WOMEN ONLY

Date Of Last Pap Smear? Any Prior Abnormal Pap? Abnormal Result Follow Up?
Of Times Pregnant? # Of Deliveries? # of Losses? Method of Delivery: # Vaginal # C-Section
Current Method Of Birth Control? ❑None ❑Other (specify):
Age At First Period? Date Of Last Period? Age At Menopause?
Date Of Last Bone Density? Normal or Abnormal?
Date Of Last Mammogram? Normal or Abnormal?
Gynecological Surgeries? (Hysteroscopy, D&C, Ablation, Hysterectomy):

U-FirstHealth
Surgery • Gynecology • Medi-Spa
12640 World Plaza Lane, Building #71
Fort Myers, FL. 33907
Phone: 239.243.8222 Fax: 239.206.4779

Date:_____

Patient Name:_____

Date of Birth:_____

YOU MAY BE CONTACTED BY U-FIRST HEALTH BY PHONE OR BY LEAVING A MESSAGE ON AN AUTOMATED ANSWERING DEVICE TO REMIND YOU OF AN APPOINTMENT, PRESCHEDULED PROCEDURE, VERIFY INSURANCE DEMOGRAPHIC INFORMATION, OR TO INFORM YOU OF TEST RESULTS. IF YOU ARE UNAVAILABLE, TO WHAT OTHER FAMILY MEMBER OR PERSON MAY U-FIRST HEALTH DISCLOSE THIS INFORMATION TO?

X:_____**RELATIONSHIP:** _____**PHONE**_____

X:_____**RELATIONSHIP:** _____**PHONE**_____

CAN WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE: YES ___ NO ____

EMERGENCY CONTACT INFORMATION ONLY

	Relationship	Address	Phone number

U-First Health
Surgery • Gynecology • Medi-Spa
12640 World Plaza Lane, Building #71
Fort Myers, FL 33907
Phone: 239.243.8222 Fax: 239.206.4779

PATIENT FINANCIAL POLICY

Thank you for selecting U-First Health as your health care provider. U-First Health payment policy is designed to provide the highest quality of health care,

- You will be responsible for payment of all fees at the time of service, if we are not an approved provider for your insurance plan. As a courtesy, we will file your insurance claim. Full payment for patients out-of-pocket (co-payments, co-insurance & deductible) are due at time of service. (The parent or guardian accompanying a minor is also responsible for all out-of-pocket expenses at the time of service).

- We accept Visa, MasterCard, Personal Checks, Travelers Checks, Cash and Care Credit.

- Patient information and proof-of-insurance are required prior to being seen by the provider. If you are unable to validate proof-of-insurance, you will be responsible for full payment at time of service.

- If your insurance denies payment for non-participation of the provider you are seeing, you will be fully responsible for rendered services, it is your responsibility to inquire as to reason for non-payment if your claim is denied. This balance will become your responsibility for payment in full.

- Your employer or group plan administrators can address coverage issues. We cannot act as a mediator with the carrier or your employer. **It is your responsibility to know which service and diagnostic facilities (i.e. lab tests, x-rays, etc.) are covered by your benefits.** We strongly encourage you to be as familiar as possible with the coverage and limitations of your healthcare insurance, to minimize the chance of unexpected problems. Any balances due, by the patient, are expected within 30 days.

- In the event you have questions regarding our bill or need assistance in making payment arrangements, the Office Manager can be reached by calling **239.243.8222**. U-First Health strives to meet personalized needs of our patients. Please understand that payment of your bill is part of your treatment, We are here to assist you.

I have read the above financial policy of U-First Health and understand my financial responsibility as a patient.

PATIENT NAME:_____**DATE:** _____

U2FirstHealth
Surgery • Gynecology • Medi-Spa
12640 World Plaza Lane, Building #71
Fort Myers, FL 33907
Phone: 239.243.8222 Fax: 239.206.4779

PAYMENT AGREEMENT CONDITIONS

"Self Pay" Patient:

I understand and acknowledge that I am responsible for full payment of services rendered to me by "U-First Health", and understand and acknowledge that any amount(s) which are designated as "patient responsibility" are payable at the time service is provided. Should any separate payment arrangement(s) be established on my self pay responsibility that are not kept current, I agree to assume any necessary fees involved in the collection of any remaining balance should I become delinquent.

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

Patients with Insurance Coverage:

I understand and acknowledge that "U-First Health" will file claim(s) for insurance payments with only those insurance companies with which "U First Health" participates as a provider. I agree to pay for any co-payment or deductible which are considered a 'patients responsibility", under the conditions of my policy, at the time service is provided.

Should my insurance carrier later determine that additional costs are not covered under the conditions of policy, and I am designated as the responsible party for such service, any remaining balance will be billed to me and I will pay the remaining balance within thirty (30) days from the date of billing. I agree to assume any necessary fees involved in the collection of this account should it become delinquent.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits for any services rendered to be paid directly to the provider or party that accepts assignment.

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

Medical Records Release:

In order to process this and/or future claim(s) or for any future application that is made to an insurance company for healthcare coverage. I authorize it-First Health". to release any necessary information required by my insurance company In order to process the claim(s). I also authorize to release any necessary information to worker's compensations company for any potential claim(s). I also authorized U First Surgery & Gynecology to obtain records from any and all prior physicians or medical facilities. I permit a copy of this authorization to be used in place of the original.

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

Advance Directive or Living Will:

Do you have a "Living Will" or "Advance Directive" related to your medical care? ❑**Yes** ❑**No**

If yes, do you wish to have a copy of your document maintained with your medical records in this office? ❑**Yes** ❑**No**