ALICIA ACON, MD, MBA, FACOG
NEW DAY OB/GYN
OBSTETRICS AND GYNECOLOGY SPECIALIST

1951 SW 172 AVENUE, SUITE 315
MIRAMAR, FLORIDA 33029
TEL: (954) 507-4604 FAX: (954) 507-4606

(PLEASE ANSWER ALL QUESTIONS AND PRINT ALL INFORMATION-ONLY PRINT NO CURSIVE)

TODAY'S DATE:_____ Patient's Full Name: _____

Date of Birth: _____ Social Security#: _____ Gender: F / M Marital Status: S M D W

Address:_____

City:_____ State:_____ Zip Code:_____

Telephone# (HOME):_____ (CELL):_____

Email:_____

Employer:_____ Address:_____

Telephone:_____ Occupation:_____ How Long? _____

Spouse Name:_____ Telephone #:_____

Date of Birth:_____ Social Security #:_____

PRIMARY CARE PHYSICIAN:_____ Telephone:_____

PHARMACY:_____ Telephone:_____

INSURANCE INFORMATION: **PRIMARY INSURANCE**

Insurance Name:_____ Telephone #:_____

Identification #_____ Group#_____ Group Name:_____

Insured's Name:_____ Insured DOB:_____ Insured SS#_____

RELATIONSHIP TO INSURED:_____

SECONDARY INSURANCE

Insurance Name:_____ Telephone #:_____

Identification #_____ Group#_____ Group Name:_____

Insured's Name:_____ Insured DOB:_____ Insured SS#_____

RELATIONSHIP TO INSURED:_____

NAME, ADDRESS, TELEPHONE# OF PERSON TO CONTACT IN CASE OF EMERGENCY: _____

_____

WHO CAN WE THANK FOR REFERRING YOU TO US? _____

BY SIGNING BELOW I GO INTO AGREEMENT AND STATE THAT ALL INFORMATION I HAVE FURNISH IS TRUE AND IN AFFECT. IF I FAIL TO FURNISH TRUE AND UP-TO-DATE INFORMATION AND THIS CAUSES INSURANCE DEFAULT IN PAYMENT OR TAKEBACK ANY MONEY, I AM FULLY RESPONSIBLE FOR FULL PAYMENT ON SERVICES RENDERED. I ALSO UNDERSTAND THAT THIS INFORMATION MUST BE UPDATED EVERY YEAR WITHOUT ANY ISSUES ON MY BEHALF.

PATIENT'S SIGANTURE:_____ DATE:_____

NEW DAY
OB/GYN, LLC
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NAME:_____ **AGE:**_____ **DATE OF BIRTH:** _____

REASON FOR VISIT: _____

ALL INFORMATION NEEDS TO BE FILLED OUT COMPLETELY IN ORDER TO SERVE YOUR MEDICAL NEEDS!!!

MEDICAL HISTORY

Have you or any family member have or have had;

	SELF	FAMILY
High Cholesterol	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Diabetic	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Tuberculosis	☐	☐
Intestinal Problems	☐	☐
Lupus	☐	☐
AIDS (HIV)	☐	☐
Hepatitis	☐	☐
Blood disorder	☐	☐
Blood Transfusion	☐	☐
Infertility	☐	☐
Endometriosis	☐	☐
Osteoporosis	☐	☐
Seizures	☐	☐
Migraines	☐	☐
Depression	☐	☐
Abnormal Pap	☐	☐
Abnormal Mammogram	☐	☐
Herpes	☐	☐
Gential Warts	☐	☐
Chlamydia	☐	☐
Gonorrhea	☐	☐
Domestic Violence	☐	☐
Sexual Problems	☐	☐

Please list all the **MEDICATIONS** you are currently taking.

_____
_____
_____
_____
_____
_____

Please list any **ALLERGIES** to medications:

_____
_____
_____
_____
_____
_____

MENSTRUAL HISTORY

Age at First Period:_____
First day of last Period:_____
_____ # of days between Periods
_____ # of days of flow.
Date of Last Physical: _____
Date of last Pap Smear: _____
Date of last Mammogram: _____

What type of Method of Contraception are you currently on:_____
_____

Please list any/all **SURGERIES** with dates: _____
_____
_____
_____
_____
_____

PREGNANCY HISTORY

of full term births _____
# of premature births _____
# of miscarriages _____
# of terminations _____
# of living children _____
#1 child Date of Birth: _____
#2 child Date of Birth: _____
#3 child Date of Birth: _____
#4 child Date of Birth: _____

LIFESTYLE

How many alcoholic drinks do you have a day?_____

How many cigarettes do you smoke a day?_____

Do you use any street drugs like cocaine or marijuana?_____
_____

Do you perform breast self-exams?__
_____

I ATTEST THAT ALL INFORMATION GIVEN BY ME IS TRUE TO THE BEST OF MY KNOWLEDGE.

_____ _____
PATIENT SIGNATURE DATE

PLEASE INITIAL EACH LINE ITEM - Informed Patient Consent

_____ Initials

I give my permission for the Physician and staff of New Day OB/GYN, LLC to treat me as deemed necessary in the exercise of their professional judgement. I understand that medical care requires my cooperation, and I will follow my doctor's orders and prescriptions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

_____ Initials

Our Office contacts your insurance company to obtain your benefits for your scheduled appointment/procedure if required by your insurance company. Please note this is **NOT A GUARANTEE OF BENEFITS OR PAYMENT**. If your insurance does not pay for any of the services rendered, you will be responsible for the balance not paid by your insurance company, regardless of reason. I understand that my medical insurance carrier may pay less than the actual bill for services, and / or apply to my co-insurance, deductible. I agree that I may be responsible for payment of all services rendered on my behalf or my dependents.

_____ Initials

I authorize and request that my insurance company, in lieu of reimbursing me directly, pay to the doctor or medical group any benefits for service rendered.

_____ Initials

We use Athena system; this system **REQUIRES A COPY OF THE INSURANCE CARD AND VALID PICTURE IDENTIFICATION CARD.** This is a MUST, without the requested information consider your appointment cancel.

_____ Initials

I authorize my doctor to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third party payers, including Medicare, Medicaid.

_____ Initials

I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company.

_____ Initials

I understand that if my insurance requires a referral or an authorization it is my responsibility to obtain it from my primary care physician. Whether to come and see a physician at New Day OB/GYN, LLC, or being referred out to any other physician/Group.

_____ Initials

I understand if I need blood draw, an injectable drug i.e., Depo shot I am responsible to pay a $25.00 convenience fee. If I need any type of paperwork filed out, I am responsible to pay a $30.00 fee. Also, if I request medical records, I understand that there is a fee associated with that request. (fee shown on request of records signature sheet.) I also understand that for any certified letter/mail sent to me (the patients) I will be charge a $20.00 fee. I also understand that there is a $50.00 fee for NO-Show or not canceling 24 hours in advance for appointments, and $150.00 for surgeries which must be cancel 30 days in advance.

_____ Initials

It is our goal to provide the best service possible to ALL our patients in a timely manner, however **some visits may take longer than others and therefore we may run behind. Your patience is appreciated, and you will receive the attention you deserve when seeing the doctor.** Because of the type of practice, we are, Obstetrics and Gynecology, we ask you to understand that the Doctor may have to leave in the middle or before seeing you to due to a delivery. We ask that you understand, and we will try to accommodate you as best possible in rescheduling your appointment. Unfortunately, emergencies do occur which may cause delays in our schedule. We will try to keep you informed as these arise.

_____ _____

Patient's Full Name Date

_____

Signature

NEW DAY OB/GYN, LLC
ALICIA ACON, MD, MBA, FACOG
OBSTETRICS AND GYNECOLOGY SPECIALIST

1951 SW 172 Avenue, Suite #315, Miramar, Florida 33029
Telephone: (954) 507-4604 Fax: (954) 507-4606

Under Florida law physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

YOUR DOCTOR HAD DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.

This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided to Florida law.

FLORIDA STATUE 458.320 (5) (g) (1)

I have read and understand the decision of the physicians of ***New Day OB/GYN, LLC***.

_____ _____
Patient's Full Name DOB

_____ _____
Signature Date

****

NEW DAY OB/GYN, LLC

Alicia Acon Ng, MD ~ OBSTETRICS & GYNECOLOGY
1951 SW 172 Avenue, Suite #315, Miramar, Florida 33029
Telephone: (954) 507-4604 Fax: (954) 507-4606

Acknowledgement of Notice of Privacy Practices

HIPAA

Patient Name & Address: _____
_____
_____

Telephone #: _____

I understand that per HIPAA guidelines/Notice of Privacy Practices, no one can obtain any medical or billing information unless I have authorized them in writing. This doesn't include my Medical Health Insurance which may require my health information for payment of services rendered to me. I understand that this office follows HIPAA guidelines.

_____ _____
Signature Date

_____ _____
Patient's Full Name DOB