**Iris Obstetrics and Gynecology**
**Registration Slip**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Statue\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Cell Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Age\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Spouse’s Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Name(if a minor)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Parent Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Employed By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Pharmacy Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Insurance**
Primary Name of Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
Secondary Name of Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Relative not living at home whom we may contact in case of emergency**
Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ordered Test:**
\_\_\_\_\_(Int) I understand that my provider at Iris Obstetrics and Gynecology, LLC may order additional services (example: blood work, ultrasound, mammogram, etc.) and it is my full responsibility to check with my insurance regarding coverage prior to having test performs. Iris Obstetrics and Gynecology is not responsible for any non-covered services.

**Financial agreement and authorization for treatment:**
\_\_\_\_\_(Int) I authorize treatment of the person named above and agree to pay all fees charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentation thereof, unless prior arrangements have been made in writing prior to billing date.
It is agreed that payment will not be delayed or withheld because of any insurance coverage or pendency of claims thereof, and proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for collection.

**Assignment of benefits:**
**\_\_\_\_\_**(Int) I hereby authorize Iris Obstetrics and Gynecology, LLC to release to my insurance company or it representative any information including the diagnosis and the records of any treatment or examination rendered to me during one (1) year from date signed of such surgical or medical care. I also authorize and request my insurance company to pay directly to the above-named doctors the amount due in my claim for basic medical, major medical and/or surgical treatment or services, by reason of such treatment or service rendered.
\_\_\_\_\_(Int) I agree that Iris Obstetrics and Gynecology, LLC may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefits payors for treatment purposes.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Print Name Signature

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you Allergic to Latex: YES OR NO
List all allergies to Medication: Food Allergies(Shellfish/Peanuts/etc):
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all Medication you take. Including over the counter medicines and vitamins.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Age of Menopause? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Age of first menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What age did you become sexually active? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Last Pap Smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. History of abnormal Pap Smear? YES OR NO Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Date of last mammogram? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Date of last bone density? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Date of last colonoscopy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. Total number of lifetime partners? Less than 5 5 or more
11. Are you sexually active currently? YES OR NO
12. Have you ever been diagnosed with a YES OR NO
sexually transmitted disease? Gonorrhea-Chlamydia-Trichmoniasis-Syphilis
13. Are you trying to become pregnant? YES OR NO
14. Are you in a relationship? YES OR NO
15. What is your form of birth control?
**NONE - CONDOMS - BIRTH CONTROL PILLS - IUD - HYSTERECTOMY - OTHER**
16. Age when you delivered your 1st child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
17. Total number of pregnancies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_ C-section \_\_\_\_\_ Vaginal \_\_\_\_\_ Miscarriage with D&C \_\_\_\_\_ Ectopic
\_\_\_\_\_ Miscarriage No D&C \_\_\_\_\_ Abortion \_\_\_\_\_Number of Living Children

Does anyone in your close family have the following conditions? Relative:

1. Heart disease of Stroke: YES OR NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. High blood pressure: YES OR NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Diabetes: YES OR NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Cancer: YES OR NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Breast Cancer: YES OR NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Uterine Cancer: YES OR NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Ovarian Cancer: YES OR NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Colon Caner: YES OR NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Other serious illness: YES OR NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. Blood clot disorder: YES OR NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. Type of diet? Regular Vegetarian Vegan Cardia Diabetic
12. Smoke cigarettes? YES OR NO
Packs per day?\_\_\_\_\_\_\_\_\_\_ Years?\_\_\_\_\_\_\_\_\_\_
13. Former Smoker YES OR NO
14. Drink Alcohol? YES OR NO
Drinks per day?\_\_\_\_\_\_\_\_\_ Per week?\_\_\_\_\_\_\_\_\_\_
15. Street drug use? YES OR NO
16. Caffeinated beverages? YES OR NO
17. Seat belt use? YES OR NO
18. Do you work outside of the home? YES OR NO
19. What is your highest level of education? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
20. What type of work do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
21. What is your religious affiliation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
22. Is a blood transfusion acceptable to you in an emergency situation? YES OR NO
23. History of domestic violence? YES OR NO
24. Marital status? Single Married Divorced Widowed Partner

Circle any procedure done on cervix? Colpscopy LEEP/LLETZ Cryo LOOP CONE

Have you had the following biopsy done? If yes, circle EMB BX Vulvar BX

List all surgery you have had and the approximate dates of the surgery.
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed with any of the following conditions? Plese **CIRCLE** all that apply.

**Cancer** **Infectious Disease**
Breast cancer of BRCA testing Chicken Pox or Shingles
Ovarian cancer HIV
Uterine (endometrial) cancer MRSA
Colon cancer Rheumatic Fever
Skin cancer Tuberculosis(TB)/Positive PPD
Cervical cancer Unusual Childhood Disease
Other cancer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiac-Heart** **Neurology – Nerve Problems**
Irregular Hearbeat Headaches or Migraines
Heart Disease Memory Loss or Dementia
High blood pressure/Cholesterol Neuropathy or Nerve Pain
Heart Murmur Seizures or Epilepsy
Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dermatology - Skin** **Orthopedi**c
Acne Chronic Back Pain
Eczema or Psoriasis Degenerative Joint Disease
Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fractures or Broken Bones
 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ear Nose or Throat - ENT** **Hematology – Blood Disorders**
Hearing loss Anemia- Low Blood Count
Seasonal Allergies Bleeding Disorder
 Blood Clotting Disorder
**Endocrinology** Blood transfusion
Diabetes Deep Vein Thrombosis(DVT) or Pulmonary Embolism
Gestational Diabetes (during pregnancy) Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Nipple discharge
Bone Loss (Osteoporosis) **Psychiatric**
Insulin Resistance Attention Deficit Disorder (ADD)
Hyperthyroidism Anxiety Disorder
Hypothyroidism Bipolar Disease
Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Depression
 Eating Disorder
**Eyes** Premenstrual Syndrome (PMS)
Cataracts Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Glaucoma
Loss of sight (Macular Degeneration) **Pulmonary**
 Asthma
**Gastrointestinal (GI)** COPD or Emphysema
Colon polyps Seasonal Allergies
Crohn’s or Ulcerative Colitis Sleep Apnea
Gallbladder Disease Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Hemorrhoids
Iritable Bowel Syndrome (IBS) **Rheumatology**
Liver Disease or Hepatitis Arthritis (Osteo or Rheumatoid)
Stomach Ulcer – Reflux (GERD) Autoimmune Disorder or Lupus
Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fibromyalgia or Chronic Pain
 Restless Leg Syndrome
**Gynecology** Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Dysplasia
Endometriosis **Urology**
Fibroids Frequent Urinary Tract Infection
Infertility Bladder Infection
PCOS Blood in the Urine (Hematuria)
Abnormal Vaginal Bleeding Interstitial Cystitis
Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kidney Disease
 Kidney Stones
**Vascular** Urinary Incontinence or Uncontrollable loss of urine
Aneurysm Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient Signature Date

**Consent for Pelvic Examination**

According to The American College of Obstetricians and Gynecologists, the pelvic examination is part of the evaluation of women presenting with many common conditions, including pelvic pain, abnormal bleeding, vaginal discharge, and sexual problems. Pelvic exams-both in the office and while under anesthesia- are also an important part of evaluation for gynecologic procedures to ensure safe completion of the planned procedure. Often, a pelvic examination is performed for women without symptoms while looking for gynecologic cancer, infections, pelvic inflammatory disease.

A pelvic examination is an assessment of the external genitalia: internal speculum examination of the vagina and cervix: bimanual palpation of the adnexa, uterus, and bladder: and sometimes rectovaginal examination.

Reasons for a pelvic exam can include (but are not limited to) health screening, abnormal bleeding, pelvic pain, sexual problems, vaginal bulge, urinary issues, or inability to insert a tampon. Other indications include patients undergoing a pelvic procedure (e.g., endometrial biopsy or intrauterine device placement). Also, pelvic examination is indicated in women with current or a history of abnormal pap results, gynecologic cancers, or toxic exposures.

 The potential benefits of a pelvic examination include the detection of vulvar, vaginal, cervical, uterine and ovarian cancers and precancers, yeast and bacterial vaginosis, trichomoniasis, and genital herpes, early detection of treatable gynecologic conditions before symptoms begin occurring (e.g. vulvar or vaginal cancer), as well as incidental findings such as dermatologic changes and foreign bodies. Additionally, screening pelvic examinations in the context of a well woman visit may allow gynecologists to explain a patient’s anatomy, reassure her of normalcy, and answer your specific questions.

The potential risks of a pelvic exam may include (but are not limited to) fear, anxiety, embarrassment (reports ranged from 10% to 80% of women) or pain and discomfort (from 11% to 60%).

There are few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluative information and carry their own set of potential risks. If you have concerns, you should discuss with your healthcare provider.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that this Patient Consent Form is required by law. I understand that I need to sign this form to show that I am making an informed decision to have pelvic examinations and I have read and understand the above.

 The provider or their delegate has explained to me the nature, purpose, and possible consequences of each procedure as well as risks involved, possible complications, and possible alternative methods of treatment. I also know that the information given to me does not list every possible risk and that other, less likely problems could occur. I was not given any guarantee from anyone about the final results of this procedure.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature Date

I understand that my provider is involved in educating tomorrow’s medical professionals and that familiarizing students with the female anatomy and instilling a physician workforce with confidence in pelvic examination skills is essential. I consent to pelvic examination by the medical professional student under the supervision of my medical provider.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature Date

**Consent to Call**

By sending artificial, prerecorded or automated calls and text messages, receiving prior written and/or oral consent is required by our practice. By signing below, you are consenting to Iris Obstetrics and Gynecology, LLC to send artificial, recorded, or automated calls/text messages to you the patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient Signature Date

If you don't want to receive artificial, recorded or automated calls/text messages from Iris Obstetrics and Gynecology, please sign below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Witness Signature Date

**Consent for Treatment**

1. I request those physicians and other healthcare professional who care for me at the practice to perform/order appropriate laboratory/diagnostic procedures and provide therapeutic treatments, which in the judgement of my physicians or other healthcare professionals are medically necessary during my medical treatment or preventative care. I also understand that it is the policy of this practice to perform urine testing on patients when appropriate, including urine pregnancy testing on every patient of childbearing age unless they have had a complete hysterectomy.

2. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made or will be made to me as to the results of any processional services that may be received by me as a patient of the practice, i.e., treatments, examinations, procedures, etc. I authorize my provider to retain, preserve and use for scientific or educational purposes, or dispose of at their convenience, any specimens or tissue take from my body during a visit. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for education purposes.

3. I consent to telephone, synchronous audio-visual or digital communication with my physicians and other healthcare professionals at the practice as an alternative to a faceto-face visit to provide care or treatment.

**I certify that I have read this form and understand its contents.**

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Iris Obstetrics and Gynecology**

**Authorization for Medical**
**Release of Information (ROI)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give permission for the person (s) listed below to accompany me in the exam room, to pick up ANY medical records on my behalf, and to speak with any employee over the telephone, with the full knowledge that any and all past and present medical history may be divulged. This consent for permission is active for one year. Any changes to this consent should be submitted in writing.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I accept (if you checked accept, please fill in the names below)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I decline

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Full Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Full Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Full Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient Signature Date

# **Iris Obstetrics and Gynecology****1811 Lucerne Terrace****Orlando, FL 32806****407-985-3007****Fax: 407-601-5853**

# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above-named practice's Notice of Privacy Practices.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Patient’s Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by Representative, state name of Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_