Emmanuela Wolloch MD.
1801 NE 123rd Street, Suite 415
North Miami, FL 33181
T: 305-935-8775 F: 305-705-2825

Patient Information Sheet

Circle one: ***New Patient*** ***Established Patient Updating Information***

First Name: _____ **Last Name:** _____ **Middle:** _____

Address: _____ **Apt#:** _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Social Security #:** _____

E-Mail Address: _____

Telephone numbers: Home: _____ **Cell:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Primary Care MD's Full Name: _____ **Phone:** _____

Pharmacy Information: _____

Address: _____

Telephone: _____ **Fax:** _____

Referred By: _____

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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 care to third party payors and / or other health practitioners. We keep a record of all health services that we provide. You can access your information at any time via the Patient Portal. You have received a copy of our privacy practices as required by law.

I understand that I am fully responsible for any and all charges incurred due to services rendered regardless of any insurance I may have. This includes any co – payments for Laboratory, etc. It is my responsibility as the Patient to understand my policies and what is included and excluded.

Signature of Patient: _____ Date: _____

Guardian Signature: _____ Date: _____

Patient Record of Disclosures

I wish to be contacted in the following manner / Check all that apply:

__Home / Cell phone: _____

OK to use detailed message Call back number only

__Work / Office phone: _____

OK to use detailed message Call back number only

Written communication:

__ OK to mail to your home: _____

__ OK to Fax / number: _____

__ Other forms of communication: _____

_____

_____

Please NOTE: We do NOT use regular EMAIL for Private Health Information as per the government requirements and ask that you not either. Thank you.

Patient Initials: _____

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MEDICAL MALPRACTICE WAIVER NOTIFICATION

Under Florida Law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **DR. WOLLOCH MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under Florida Law, subject to certain conditions: Florida Law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law.

ACKNOWLEDGEMENT:

_____ _____

Patient Signature Date

EMMANUELA WOLLOCH M.D. FACOG

Credit Card Payment Form

In order to better serve our Patients, We ask that you fill out the below information. Your Credit Card information will be placed securely in your file and be used to:

- Hold your appointments
- Cover any cancellation fees that you may acquire
- To pay for your Nutraceuticals and the shipping that you may order

The validity of the Credit Card will be verified prior to services being rendered.

Please complete the information area below to authorize future payment for any balance which you may incur with our office. Your billing information will be kept in a locked electronic file and guarded by the same privacy standards used for your Medical Records.

I authorize Emmanuela Wolloch, MD, P.A. to keep my signature and information on file and to charge my credit card for the above incidences for the next 12 months.

PATIENT NAME _____ DOB_____

Credit Card Account Information

NUMBER: _____

Expiration Date: _____Card Type : MC _____ Visa_____ AMEX_____
Customer Code / CVV: _____(3 or 4 digit number on back / front of card)
Billing Zip Code:_____
Billing Address: _____

NAME ON CARD: _____

CardHolder's Signature: _____ Date_____

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Blood Drawing Policy

Please be aware that your Insurance Company may have a deductible, a Co-Pay, or may NOT pay in total or in part for your laboratory tests. **It is the responsibility of each Patient to know what their Insurance companies cover, how they pay for any service rendered, and what the Patient's financial responsibility is.** Our office will charge a drawing fee that covers our expenses that is your responsibility. If you do not want to have your blood drawn at the office, an order will be given so that you may take it to your laboratory.

All blood work drawn MUST be ordered by Dr. Wolloch.

I understand the above information and that I am responsible for any payments as noted above.

PATIENT SIGNATURE: _____

PRINT NAME: _____

DATE: _____

EMAIL WAIVER

The Heath Insurance Portability and Accountability Act of 1996 (HIPAA) set standards for the protecting the rights of individuals (Patients). Emmanuela Wolloch MD,PA follows the laws that grant every individual to the privacy and confidentiality of their health information. To comply with HIPAA regulations, Email correspondence that contains protected health information must be sent encrypted. To that end, the Practice uses a state of the art Health Information System that you will be given a password and instructions to enable you to view your health record. If you wish to send or receive unencrypted (unsecure) regular EMAIL sent to you for your convenience, you must sun the following waiver:

I, _____, request that for my convenience, Emmanuela Wolloch MD, PA correspond with me by unencrypted (unsecure) email. I understand that EMAILS sent to me may contain protected health information. I further understand that these emails and attachments are NOT secure and may be viewed by others. I agree to hold harmless E. Wolloch MD, PA, its officers, agents, Employees, and any contracted health providers from any and all liability, loss, damages, costs or expenses which are sustained, incurred or required arising from the transmission of unencrypted emails and attachments.

I direct E Wolloch MD, PA to send all emails to this address:

_____.

This waiver will remain in force until revoked in writing. It may be revoked in writing at any time.

Signed and dated this _____ day of _____, 20_____.

_____

_____ Witness

EMMANUELA WOLLOCH M.D. FACOG

Dr. Wolloch's Hormone PROTOCOL

Initial Visit	500.00

(Includes 1st follow up visit either in person or telephone consultation within a MONTH)

Labs	Contingent
3 month follow – up	250.00
6 month follow – up	250.00

All Patients MUST have annual Pap / Mammography on file and attend ALL Appointments to continue treatment.

I _____ Understand and agree to the terms of the protocol. There are no exceptions.

Date: _____

Signature: _____

EMMANUELA WOLLOCH M.D. MIAMI'S PRIMER PRIVATE GYNECOLOGIST.
1801 NE 123 STREET, SUITE 415, NORTH MIAMI, FL. 33181
305 – 935 – 8775
EMMANUELAWOLLOCHMD.COM

This is an extensive health survey based on the work of Christiane Northrup, M.D., author of Women's Bodies, Women's Wisdom and The Wisdom of Menopause, which I believe are two of the best books on women's health available. Please take your time to fill out all of the questions, and feel free to address any of the questions with me or my Staff privately. Thank you.

NAME: _____

AGE: _____ **DATE:** _____

MARITIAL STATUS: Single Married Divorced Widow

INTENTION FOR THIS APPOINTMENT-(What are the top 3 symptoms you would like help with today?)_____

_____

_____

CURRENT/RECENT HEALTH CARE PROVIDERS/ PRIMARY CARE PHYSICIAN

Name	Dates	Care Provided

GENERAL HEALTH: Excellent Good Fair Poor

ALLERGIES

Drug allergies (penicillin, etc.):

_____

Allergies to foods, pollens, etc.:

_____

MEDICATIONS

If this is a hormone consult, please list all hormones you have taken in the past, including birth control pills, infertility treatments, thyroid or adrenal hormones and all estrogen and progesterones.

Drug Name	When Used	Why Used	Side Effects

Current Prescription Medications (Include dosage):

_____

_____

_____

Vitamins/Supplements/Herbs_____

_____

_____

PAST MEDICAL CONDITIONS (For current problems, note under Current Medical Problems)

Breast cancer
Cervical cancer
Ovarian cancer
Uterine cancer
Other Cancer_____
Depression/anxiety
Rheumatic fever
Jaundice/hepatitis
Chronic Fatigue/Epstein Barr
Fractures
Other_____

High blood pressure
Stroke
Varicose veins
Phlebitis
Clotting defects
Arthritis
Osteoporosis
Fibromyalgia
Asthma
Colitis

Bleeding tendencies
Blood transfusion
Heart trouble
Diabetes
Kidney trouble
Epilepsy
Eating disorder
Hypo/Hyperthyroid
Environmental Illness
Chemical Sensitivity

CURRENT MEDICAL SYMPTOMS/ CONDITIONS

Circle any symptoms of present significance.

GENERAL
Fever or chills
Hot flashes
Night sweats

Unusual hair growth
Skin changes
Weight change

Fatigue/ low energy
Cold extremities
Cold intolerance

ABDOMEN
Bloating
Heartburn
Indigestion
Diarrhea

Constipation
Hemorrhoids
Flatulence (gas)
Cramps or pain

Change in bowel habits
Vomiting
Nausea
Bloody or tarry stools

HEAD
Headaches
Dizziness

Visual defects
Hearing defects

Sinus congestion
Fainting spells

BLADDER
Frequent urination
Painful urination
Blood in urine

Inability to hold urine
Inability to empty bladder
Nighttime urination

CHEST
Chest pain
Palpitations

Shortness of breath
Chronic cough

Heart murmur
Coughing up blood

Mitral valve prolapse
Wheezing

BREASTS
Lumps Bleeding Discharge Tenderness Other

HOSPITALIZATIONS/OPERATIONS

Dates	Hospital	Diagnosis/Operation	Doctor

PREGNANCIES (including miscarriages and abortions)

Dates	How far along	Sex	Weight	Problems

GYNECOLOGICAL HISTORY

Date last period began: _____ Date of last pelvic exam: _____
Date of last Pap Smear: _____ Age of first period: _____
Was the above normal? _____
Age of menopause: _____ (note: If menopausal, answer the questions below for when you did)
Date of last Mammogram: _____
Do you do self-breast exams? _____ How often? _____
Have you had a bone density screen? _____ When? _____ Results _____
Have you ever had an abnormal Pap? _____ When: _____
Are you sexually active? _____ Do you have intercourse? _____ Do you practice safe sex? _____
Are you trying to get pregnant? _____ How long? _____
Current birth -control method: _____ Used for how long? _____
Undesirable side effects _____ ? _____
Past birth control methods: _____
Normally (not on pills), the number of days from the start of one period to the start of the next: _____
Number of days of flow: _____ Amount of bleeding: _____
Premenstrual symptoms: _____ Starting when? _____
Amount/severity of cramps: _____
Any current changes in your normal pattern? _____
Any bleeding between periods? _____ When? _____
Any unusual pelvic pain, pressure, or fullness? _____ Describe: _____
Any unusual vaginal discharge or itching? _____ Describe: _____
How long? _____ Past treatment: _____
Menopausal Symptoms: _____
Painful Intercourse/Vaginal dryness? _____
Any sexual concerns to discuss? _____
Any past history of tubal infection? _____ Any past history of DES exposure? _____
Any past history of sexually transmitted disease? (Herpes, chlamydia, genital warts) _____
Treatment used? _____

FAMILY HISTORY

MEMBER: LIVING? AGE? IMPORTANT DISEASES CAUSE OF DEATH & AGE

Alcoholism, High Blood Pressure, Cancer, Diabetes, Heart Disease, Osteoporosis, Depression, Psychiatric illness, other addiction, other illness, domestic/sexual violence?

Mother: _____
Father: _____
Sister(s): _____
Brother(s): _____
Maternal Grandmother: _____
Paternal Grandmother: _____
Maternal Grandfather: _____
Paternal Grandfather: _____
Paternal Aunt(s): _____
Maternal Aunt(s): _____
Maternal Uncle(s): _____
Paternal Uncle(s): _____
Children/Others: _____

HABITS

Dietary preferences/restrictions: _____
What did you eat/drink in the past 3 days (include all snacks, sodas, water, alcohol, coffee, fast food etc.)
Breakfast: _____
Lunches: _____
Dinners: _____
Snacks: _____
Drinks: _____
Have you ever been diagnosed with an eating disorder or feel like you may have one? _____
_____
Describe your body image: _____
Routine physical exercise? Type of exercise: _____
For how many minutes? _____ How often? _____
Tobacco use (how much): _____ Previously? _____ How long? _____
Alcohol use (how much): _____ How often? _____
Caffeine use (how much/often): _____
Mood altering substance use? (I.e. marijuana, cocaine, prescription drugs(past and present):
_____
How often do you laugh? _____
What do you do to nurture yourself? _____
How do you express yourself creatively? _____
What gives you joy/ passion? _____
Do you have a spiritual practice? _____

STRESSES

(Family, work, self, etc.):

_____
_____
_____

One in every 3-4 women has been a victim of sexual abuse and/or physical violence. Is this an issue for us to discuss? _____

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CONSENT FOR BIO-IDENTICAL HORMONE REPLACEMENT THERAPY

To The Patient:
Backgrounds: You have been diagnosed with or have an increased risk of having a hormone deficiency (ies) and your doctor has recommended treatment with bio-identical hormone replacement therapy (HRT). Some of the Bio-Identical hormone preparations that may be prescribed for you are regulated by the pharmacy compounding law, which is part of pharmacy compounding laws. The use of this therapy as it relates to your diagnosis, while common in alternative and weight loss practices, may be debated in the traditional medical community.

You have the right, as a patient, to be informed about your condition and the recommended conventional, integrative, complementary, alternative, non-conventional or non-standard procedures to be used so that you make an informed decision whether or not to undergo the procedures after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may have the information needed to give or withhold your consent to the procedure or treatment.

NOTICE: Refusal to consent to the innovative, integrative, complementary or nonstandard procedure shall not affect your right to future care or treatment.

Therapeutic Basis: Many individuals have inadequate hormone levels despite technically normal blood tests. Some individuals suffering symptoms related to menopause or andropause or inability to lose weight may also benefit from these therapies. Bio-identical hormone replacement therapy can be used to augment hormone levels in a number of conditions where diminished hormone levels are evident.

☐ Estrogen therapy can maintain vaginal and urethral function and slow the progression of osteoporosis. It may also improve sleep, decrease pain and perhaps cognitive function, and improve libido and overall wellbeing. This therapy may contain one or any combinations of the following medications: estriol, estradiol, and/or estrone.

☐ Progesterone hormone replacement therapy can offer protection from endometrial cancers, treatment of irregular menstruation, and other low progesterone conditions. It also can improve sleep quality and decrease anxiety. For males, low dose progesterone therapy in conjunction with testosterone therapy can maximize the hormone ratios, reducing side effects.

☐ Testosterone replacement therapy is used to treat symptoms or lab tests suggesting suboptimal hormone levels as determined by your doctor. Low testosterone is associated with elevated cholesterols, Blood Pressure, Diabetes and prostate problems. There are ongoing discussions within the medical community whether treating to optimize testosterone will increase or decrease these problems.

Objectives: Bio-identical hormone replacement therapy is implemented to optimize hormone levels in the blood, helping to reduce symptoms associated with low levels of these hormones.

Potential Risks:
Safety of any of these hormones during pregnancy cannot be guaranteed. Notify your physician or if you are pregnant, suspect that you have become pregnant, or if you are planning to become pregnant during this therapy

Estrogen Therapy: Bio-identical estrogens are available in various forms including oral capsules, troches, patches and topical creams. Adverse reactions may include bloating, breakthrough bleeding, breast swelling and tenderness, fluid retention, weight gain, liver cysts, death (e.g.-from blood clots or cancer) and mood swings.

High potency conjugated estrogens (e.g. Premarin), and perhaps even estradiol, have been associated with an increased risk of breast cancer and blood clots (the latter especially in smokers). Estriol may carry a lower risk of breast cancer and may even protect against breast cancer. Nonetheless, the whole area of estrogen replacement is undergoing further evaluation. Do not take estrogen if you have breast cancer.

☐ **Progesterone Therapy:** Bio-identical progesterone is available in various forms including oral capsules, troches, vaginal or rectal suppositories, and topical creams or gels. Progesterone therapy may be sedating, so it is recommended to coordinate dosing with sleep cycle. Adverse reactions may include bloating, breakthrough bleeding, missed menstrual cycles, breast swelling and tenderness, fluid retention, weight gain, sedation, and depression.

☐ **Testosterone Therapy:** Bio-identical testosterone therapy is available in various forms including sublingual drops, troches, topical creams, and injection. Side effects include acne, chronic priapism (persistent, abnormal erection of the penis), change in libido, angina or heart attacks, hirsutism (facial hair growth) and scalp hair loss, clitoral engorgement, voice changes, or water retention. Because it may improve insulin resistance in males, diabetics who use insulin should monitor glucose levels closely, as less insulin may be needed. Check with your physician before adjusting your dose of insulin. If using a formulation of testosterone that is applied to the skin, a local irritation may occur. In women, excessive testosterone or DHEA doses could increase the risk of diabetes or facial hair.

Although the use of bio-identical hormone replacement therapy has been shown in many studies to be safer than synthetic hormone replacement therapy, the risk of cancer-related side effects is still possible. In fact, there are physicians who do not agree with use bioidentical hormones

Statement of patient:
I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications have been explained to me. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. I agree to proceed with treatment and to comply with recommended dosages.

I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by physician, my primary care physician, or other specialist. I agree to see my primary care physician, gynecologist, or other practitioner for regular monitoring and for preventative measures that may include but are not limited to complete physicals, rectal examinations and/or colonoscopy, EKG, mammograms, pelvic/breast exams, pap smears, prostate exams, PSA levels, etc. at least on a yearly basis.

I agree to immediately report to my physician any adverse reaction or problem that might be related to my therapy. I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as to not being treated. Those risks and potential complications have been explained to me and I agree that I have received information regarding those risks, potential

Complications and benefits, and the nature of Bioidentical and other hormone treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefit from the administration of bio-identical hormone therapy.

I certify this form has been fully explained to me, that I have read it or have had it read to me and that I understand its contents. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits.

I agree to the therapy described above. I have been educated on the benefits, risks, and possible adverse reactions associated with bio-identical hormone replacement therapy.

Signature of Patient_____Date

Name (PRINT) _____

If patient is a minor Parent/Legal Guardian Signature_____Date

Name (PRINT)_____Relationship

Statement of clinical educator:
I have explained the therapy, its intended benefits and risks, and possible reactions to the patient. I have confirmed that the patient has no further questions and wishes to initiate bio-identical hormone replacement therapy.

Name of Physician Explaining Procedures: _____

I have explained the risks and benefits of the therapy as detailed above. The patient has verbalized to me his/her understanding of those risks and benefits giving verbal consent to initiate this therapy.

_____

Physician Signature Date