

**Patient Information**

Name: \_\_\_\_\_

Last

First

MI

Patients Address: \_\_\_\_\_

Street Address

City

State

ZIP

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Employer \_\_\_\_\_

How would you like to be contacted for your test results/appointments? (circle one) Home Work Cell

It is ok for us to leave messages at this number? \_\_\_\_\_ Yes \_\_\_\_\_ No, please only speak directly with me.

**Insured/Spouse/Parent/Guardian Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**Medical Procedure Policy**

I hereby authorize the certified providers of Obstetrics & Gynecology of Atlanta to provide obstetrical and gynecology care for me. I give the providers permission to perform any necessary procedures after reviewing the procedure and the associated risks.

**A Division of Atlanta Women's Health Group P.C.**

**Financial Policy**

We are committed to meeting your health care needs. Our goal is to keep your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank may result in a \$25.00 returned check fee being charged to your account.
2. It is your responsibility to provide us with your current address, telephone number, and insurance information at each visit.
3. It is your responsibility to contact your insurance carrier to confirm that our physicians participate on your plan. If you see a doctor that is not currently on your plan, you will be responsible for payment in full.
4. If your plan requires a referral it is your responsibility to obtain this prior to being seen by the doctor. If we are required to obtain that referral for you, please notify our office 72 hours prior to the specialist visit so that we can have ample time to acquire this information from your insurance company.
5. All co-payments are due at the time of service. A \$25.00 service fee will be charged for failure to pay the co-pay amount at the time of service.
6. If you miss your appointment, you may be charged a No-Show fee of \$25.00 for each appointment missed.
7. Laboratory services may be provided by Quest Diagnostics, Lab Corp., Genzyme, and NTD Laboratory. All of these are contracted labs. Labs billed by our office will be billed by Phyttest, an independent lab billing service.
8. All medical records request must be in writing and received in our office 72 hours prior to the date needed. Records over 10 pages will only be mailed not faxed and all medical records request will have a fee based on the number of pages. The range of fees for this service is from \$10.00 - \$50.00. Occasionally, the fee could be over \$50.00 if there are excessive pages to copy.

**I understand that I am responsible for any amount that my insurance does not cover.**

**I have reviewed a copy of Obstetrics & Gynecology of Atlanta Notice of Privacy Practices**

**\*\*\*\*For your convenience, we accept Cash, Checks, Visa, MasterCard, American Express and Discover\*\*\*\***

Your signature below signifies your understanding and willingness to comply with this policy.

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

# OBSTETRICS & GYNECOLOGY OF ATLANTA

Patient Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Referred By: \_\_\_\_\_ Age: \_\_\_\_\_ Date of last period: \_\_\_/\_\_\_/\_\_\_

Reason for visit:         Routine Physical         Problem

Describe Problem: \_\_\_\_\_

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## CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

MAJOR ILLNESSES	YES	NO		YES	NO
Abnormal Pap Smear			Hepatitis / Liver Disease		
Anxiety			High Blood Pressure		
Arthritis			High Cholesterol		
Asthma			Kidney Infections (not bladder or UTI)		
Blood transfusions			Kidney Stones		
Bowel Disorder			Migraine Headaches		
Breast Cancer			Osteoporosis / Osteopenia		
Cancer (what type?)			Rheumatic Fever		
Chronic Lung Disease			Seizure Disorder		
Deep vein thrombosis /Pulmonary embolism			Sexually Transmitted Disease (what type?)		
Depression			Stroke		
Diabetes			Tuberculosis - TB		
Glaucoma			Thyroid Disease		
Heart Disease			Ulcers		
			OTHER:		

## WHEN WAS YOUR LAST IMMUNIZATION?

	DATE		DATE
Last PAP Smear		Flu shot	
Mammogram		Gardasil/HPV	
Colonoscopy / Sigmoidoscopy		Hepatitis	
Bone Density		TB Skin Test	
Tetanus/Tdap		OTHER:	

## PLEASE LIST ANY INJURIES OR ILLNESSES:

TYPE	DATE	TYPE	DATE

## PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY/REASON	DATE	SURGERY/REASON	DATE

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:**

DRUG NAME	DOSAGE	PHYSICAN	DRUG NAME	DOSAGE	PHYSICAN

ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.?)	List:
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**CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:**

MAJOR ILLNESSES	YES	NO	WHAT BLOOD RELATIVE? Mother, Father, etc.
Alzheimer's Disease			
Arthritis			
Bowel Disease (what type?)			
Breast Cancer			
Cancer (what type?)			
Colon polyps			
Chronic Lung Disease			
Deep vein thrombosis / Pulmonary embolism			
Depression / Mental illness / Suicide			
Diabetes			
Glaucoma			
Heart Disease			
Hepatitis / Liver disease			
High Blood Pressure			
High Cholesterol			
Osteoporosis			
Stroke			
Thyroid Disease			
OTHER:			

**YOUR GYN HISTORY**

Do you use birth control?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Condoms	<input type="checkbox"/> Nuvaring
<input type="checkbox"/> Depo Provera	<input type="checkbox"/> Birth Control Patch
<input type="checkbox"/> Diaphragm	<input type="checkbox"/> None
<input type="checkbox"/> IUD - Kind	<input type="checkbox"/> Natural Family Plan / Rhythm
- Date Inserted:	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Birth Control Pill	<input type="checkbox"/> Vasectomy
- Name:	<input type="checkbox"/> Withdrawal
<input type="checkbox"/> Contraceptive Foam / Jelly	<input type="checkbox"/> Other:

What age did you have your first period: _____	
How many days are there from start of period to start of next period _____ days	
How long does your period last? _____ days	Flow: <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy
Do you have clots? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have bleeding between periods? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have cramps? <input type="checkbox"/> No <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe	Do you have pelvic pain at other times? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you gone thru Menopause <input type="checkbox"/> Yes <input type="checkbox"/> No	At what age: _____

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## YOUR OB HISTORY

	NUMBER	NUMBER
Total # of pregnancies		Full term births
Premature		Abortions Induced
Miscarriages		Living children

On the chart below, please fill in answers for each pregnancy, including abortions or miscarriages.

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight Sex	Del Type Vag/CSection	Anes	Early Labor?	Wt Gain	Comments / Complications	Location
1				M						
				F						
2				M						
				F						
3				M						
				F						
4				M						
				F						
5				M						
				F						
6				M						
				F						

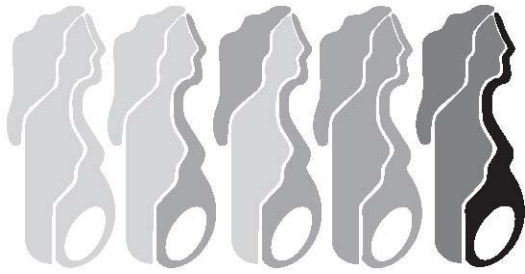
## SOCIAL HISTORY

PLEASE LIST HABITS	
Do you use Seat Belt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you do a Self Breast Exam	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you Drink Milk	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glasses per day:	
Do you eat cheese or other dairy products	<input type="checkbox"/> Yes <input type="checkbox"/> No
Servings per day:	
Do you Take Calcium	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name and Dosage:	
Do you Exercise	
<input type="checkbox"/> None <input type="checkbox"/> Less than 3 times per week <input type="checkbox"/> More than 3 times per week	
Are you Sexually Active	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have sex with?	<input type="checkbox"/> Husband <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both
New sexual partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No How long? _____ First Intercourse at Age: _____
Lifetime sexual partners	<input type="checkbox"/> Husband <input type="checkbox"/> Less than 5 <input type="checkbox"/> More than 5
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Engaged
Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Packs per day: _____	Number of Years: _____
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drinks per day: _____	Drinks per week: _____
Drug User	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kind: _____	Frequency: _____
History of abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Sexual	
List all Natural or Herbal remedies, over the counter drugs, vitamins or minerals you are taking	List: _____
Occupation:	
Race	<input type="checkbox"/> White <input type="checkbox"/> African/American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**REVIEW OF SYSTEMS:**  
**PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLIES TO YOU NOW.**

CONSTITUTIONAL	NOTES	GENITOURINARY (CONT)	NOTES
Weight Loss <input type="checkbox"/>		Decreased sex drive <input type="checkbox"/>	
Weight Gain <input type="checkbox"/>		Painful intercourse <input type="checkbox"/>	
Fever <input type="checkbox"/>		Possible Pregnancy <input type="checkbox"/>	
Fatigue <input type="checkbox"/>		Genital Sores <input type="checkbox"/>	
Night Sweats <input type="checkbox"/>		Vaginal discharge <input type="checkbox"/>	
Hot Flashes <input type="checkbox"/>		<b>SKIN</b>	
<b>EYES</b>		Rashes <input type="checkbox"/>	
Double vision <input type="checkbox"/>		Itching <input type="checkbox"/>	
Vision changes <input type="checkbox"/>		Skin Dryness <input type="checkbox"/>	
<b>HENT</b>		Skin Lesions <input type="checkbox"/>	
Headaches <input type="checkbox"/>		Changes to Lesions or Moles <input type="checkbox"/>	
Dizziness <input type="checkbox"/>		Acne <input type="checkbox"/>	
Sore Throat <input type="checkbox"/>		<b>NEUROLOGICAL</b>	
Sinus Pain <input type="checkbox"/>		Muscular Weakness <input type="checkbox"/>	
Nose Bleeding <input type="checkbox"/>		Numbness or Tingling <input type="checkbox"/>	
Thyroid Mass <input type="checkbox"/>		Difficulty Concentrating <input type="checkbox"/>	
Neck Pain <input type="checkbox"/>		Memory Difficulties <input type="checkbox"/>	
<b>BREAST</b>		Speech Difficulties <input type="checkbox"/>	
Lumps <input type="checkbox"/>		Seizures <input type="checkbox"/>	
Tenderness <input type="checkbox"/>		Loss of Balance <input type="checkbox"/>	
Swelling <input type="checkbox"/>		<b>MUSCULOSKELETAL</b>	
Discharge <input type="checkbox"/>		Joint Pain or Swelling <input type="checkbox"/>	
Pain in Breast <input type="checkbox"/>		Muscle Pain <input type="checkbox"/>	
Abn Changes in Breast <input type="checkbox"/>		Back Pain <input type="checkbox"/>	
<b>CARDIOVASCULAR</b>		<b>ENDOCRINE</b>	
Chest Pain <input type="checkbox"/>		Loss of Hair <input type="checkbox"/>	
Irregular Heart Beats <input type="checkbox"/>		Difficulty Tolerating Cold <input type="checkbox"/>	
Rapid Heart Rate <input type="checkbox"/>		Difficulty Tolerating Heat <input type="checkbox"/>	
Fainting <input type="checkbox"/>		<b>PSYCHIATRIC</b>	
Swelling of legs <input type="checkbox"/>		Anxiety <input type="checkbox"/>	
Varicose veins <input type="checkbox"/>		Depression <input type="checkbox"/>	
<b>RESPIRATORY</b>		Impulsive Behavior <input type="checkbox"/>	
Wheezing <input type="checkbox"/>		Suicidal Thoughts <input type="checkbox"/>	
Cough <input type="checkbox"/>		Excessive Anger <input type="checkbox"/>	
Shortness of breath <input type="checkbox"/>		Mood Swings <input type="checkbox"/>	
Spitting up blood <input type="checkbox"/>		Emotional Abuse <input type="checkbox"/>	
<b>GASTROINTESTINAL</b>		Physical Abuse <input type="checkbox"/>	
Nausea <input type="checkbox"/>		Sexual Abuse <input type="checkbox"/>	
Vomiting <input type="checkbox"/>		<b>HEMATOLOGIC / LYPHATIC</b>	
Diarrhea <input type="checkbox"/>		Bruises, frequent or easily <input type="checkbox"/>	
Constipation <input type="checkbox"/>		Cuts do not stop bleeding <input type="checkbox"/>	
Abdominal Pain <input type="checkbox"/>		Enlarged lymph nodes <input type="checkbox"/>	
Bloody / Black Stool <input type="checkbox"/>		<b>ALLERGIC / IMMUNOLOGIC</b>	
Hemorrhoids <input type="checkbox"/>		Frequent illness <input type="checkbox"/>	
Jaundice <input type="checkbox"/>		Seasonal Allergies <input type="checkbox"/>	
<b>GENITOURINARY</b>		<b>OTHER</b>	
Urgency of urination <input type="checkbox"/>		1 <input type="checkbox"/>	
Frequency of urination <input type="checkbox"/>		2 <input type="checkbox"/>	
Pain with urination <input type="checkbox"/>		3 <input type="checkbox"/>	
Nighttime urination <input type="checkbox"/>			
Losing urine <input type="checkbox"/>			
Blood in urine <input type="checkbox"/>			



# Obstetrics & Gynecology of Atlanta

**Ob/Gyn**  
 Thomas E. Sharon, M.D.  
 Kirsten L. Franklin, M.D.  
 Genevieve L. Fairbrother, M.D.  
 Charles D. Wooten, M.D.  
 Claire A. Parker, M.D.  
 Keisha N. Dennard-Hall, M.D.  
 Jill J. Henke, M.D.  
 Christopher E. Bassil, M.D.

**Nurse Practitioners**  
 Dianne McMullen, CFNP

**Nurse Midwives**  
 Dixie Shepard, CNM  
 Christine Gordon, CNM  
 Stephanie Beasley, CNM  
 Jennifer Apke, CNM  
 Janice Taliff, CNM

## Authorization to Release Medical Information

Phone 404-252-1137 Fax 404-506-9221

Patient Name (Print): \_\_\_\_\_

Current Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Who has the information you would like released?

Dr. Name: \_\_\_\_\_ Business Name: \_\_\_\_\_

Address: \_\_\_\_\_ Ste. # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### To Whom should the information be sent?

Name: \_\_\_\_\_ Business Name: \_\_\_\_\_

Address: \_\_\_\_\_ Ste. # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### Reason for Request:

Selected new physician in the area |  Second opinion / Consult |  Change of Insurance |  Moving out of town  
 Other \_\_\_\_\_

### Portion of records to be released:

Entire medical record |  Other (describe in detail) \_\_\_\_\_

**Restrictions:** I understand that the recipient of this information may not use or disclose this information except for the express purpose identified above, unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

**Notice:** Unless specified below, this authorization is for full disclosure of all records, including clinical findings, diagnoses, treatments, assessments, recommendations for further care, names of all health care personnel, dates of hospitalization and ambulatory visits, charges and any information that may be related to drug, alcohol, psychiatric conditions, and /or sexually transmitted diseases, including HIV/AIDS information. By signing this form I acknowledge and understand there may be a charge for the administration and copying of my medical records.

### Exclusions (Please initial):

\_\_\_\_\_ Drug / Alcohol      \_\_\_\_\_ Mental Health / Psychiatric      \_\_\_\_\_ Sexually Transmitted Disease      \_\_\_\_\_ HIV / AIDS

This authorization is valid for one year or until \_\_\_\_\_, whichever comes first.

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

**A Photocopy of this release is as valid as the original**

I understand that this consent is only for the specific purpose stated and may be revoked at any time. This consent expires automatically when its purpose has been accomplished.

Northside • 1100 Johnson Ferry Road, N.E. • Suite 800 • Sandy Springs, Georgia 30342 • (404) 252-1137  
 East Cobb • 1519 Johnson Ferry Road • Suite 175 • Marietta, Georgia 30062 • (770) 565-2233  
 Johns Creek • 3890 Johns Creek Parkway • Suite 300 • Suwanee, Georgia 30024 • (678) 775-2300