

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

PROBLEM/ANNUAL RETURN VISIT

Patient Name _____

Date _____ Birthdate _____ Patient Age _____

BP _____ / _____ Weight _____ Height _____

Nursing Notes _____

Mammo Today _____ Ultrasound Today _____ Bone Density Today _____

Reason for today's visit _____

Any new gynecological problems? _____

Date last period began _____ Allergies _____

1. Married or Single 2. Heterosexual or Lesbian 3. Monogamous Y N

How many times have you been Pregnant? _____ How many children do you have? _____

Are you trying to avoid Pregnancy Y N

How do you prevent Pregnancy?

Birth Control Pills (brand) _____ IUD Tubal Ligation No Sexual Activity

Condoms Rhythm Method Hysterectomy None

Nuva Ring Orth Evra Patches Vasectomy

Vaccinations / Boosters

1. Have you been vaccinated for Hepatitis A? Yes or No

2. Have you been vaccinated for Hepatitis B? Yes or No

3. Have you had a pertussis (whooping cough) booster? Yes or No

4. Have you had a recent tetanus booster? Yes or No

5. Have you had a flu shot in the last flu season? Yes or No

6. If under 25, have you had cervical cancer vaccinations? Yes or No

Comments: _____

Current Medications (please include dosages) _____

Past Gyn Surgeries: _____

When was your last Mammogram _____ When was your last Colonoscopy _____

When was your last Bone Density Test _____

Do you have a family history of breast, ovarian, or colon cancer (supply details)? YES NO

Detail: _____

Have you had an abnormal pap in the last 5 years? _____ What type of treatment or follow up did you have for this? _____

Please describe any changes in personal, social, or health status since your last visit here.

FILL OUT FOR ANNUALS ONLY

NAME: _____ BIRTHDATE: _____ / _____ / _____

REVIEW OF SYSTEMS: CHECK ANY PROBLEMS THAT ARE NEW OR YOU WISH TO ADDRESS AT THIS VISIT

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"/>				
EYES			SKIN		
Double vision	<input type="checkbox"/>		Rashes	<input type="checkbox"/>	
Vision changes	<input type="checkbox"/>		Itching	<input type="checkbox"/>	
			Skin Dryness	<input type="checkbox"/>	
HENT			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"/>				
Sinus Pain	<input type="checkbox"/>		NEUROLOGICAL		
Nose Bleeding	<input type="checkbox"/>		Muscular Weakness	<input type="checkbox"/>	
Thyroid Mass	<input type="checkbox"/>		Numbness or Tingling	<input type="checkbox"/>	
Neck Pain	<input type="checkbox"/>		Difficulty Concentrating	<input type="checkbox"/>	
			Memory Difficulties	<input type="checkbox"/>	
BREAST			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"/>				
Discharge	<input type="checkbox"/>		MUSCULOSKELETAL		
Pain in Breast	<input type="checkbox"/>		Joint Pain or Swelling	<input type="checkbox"/>	
Abn Changes in Breast	<input type="checkbox"/>		Muscle Pain	<input type="checkbox"/>	
			Back Pain	<input type="checkbox"/>	
CARDIOVASCULAR					
Chest Pain	<input type="checkbox"/>		ENDOCRINE		
Irregular Heart Beats	<input type="checkbox"/>		Loss of Hair	<input type="checkbox"/>	
Rapid Heart Rate	<input type="checkbox"/>		Difficulty Tolerating Cold	<input type="checkbox"/>	
Fainting	<input type="checkbox"/>		Difficulty Tolerating Heat	<input type="checkbox"/>	
Swelling of legs	<input type="checkbox"/>				
Varicose veins	<input type="checkbox"/>		PSYCHIATRIC		
			Anxiety	<input type="checkbox"/>	
RESPIRATORY			Depression	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>		Impulsive Behavior	<input type="checkbox"/>	
Cough	<input type="checkbox"/>		Suicidal Thoughts	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>		Excessive Anger	<input type="checkbox"/>	
Spitting up blood	<input type="checkbox"/>		Mood Swings	<input type="checkbox"/>	
			Emotional Abuse	<input type="checkbox"/>	
GASTROINTESTINAL			Physical Abuse	<input type="checkbox"/>	
Nausea	<input type="checkbox"/>		Sexual Abuse	<input type="checkbox"/>	
Vomiting	<input type="checkbox"/>				
Diarrhea	<input type="checkbox"/>		HEMATOLOGIC /		
Constipation	<input type="checkbox"/>		LYMPHATIC		
Abdominal Pain	<input type="checkbox"/>		Bruises, frequent or easily	<input type="checkbox"/>	
Bloody / Black Stool	<input type="checkbox"/>		Cuts do not stop bleeding	<input type="checkbox"/>	
Hemorrhoids	<input type="checkbox"/>		Enlarged lymph nodes	<input type="checkbox"/>	
Jaundice	<input type="checkbox"/>				
			ALLERGIC / IMMUNOLOGIC		
GENITOURINARY			Frequent illness	<input type="checkbox"/>	
Urgency of urination	<input type="checkbox"/>		Seasonal Allergies	<input type="checkbox"/>	
Frequency of urination	<input type="checkbox"/>				
Pain with urination	<input type="checkbox"/>		OTHER		
Nighttime urination	<input type="checkbox"/>		1	<input type="checkbox"/>	
Losing urine	<input type="checkbox"/>		2	<input type="checkbox"/>	
Blood in urine	<input type="checkbox"/>		3	<input type="checkbox"/>	