OBSTETRICS & GYNECOLOGY OF ATLANTA

PATIENT REGISTRATION FORM

Account # _____ Date: _____/_____/_____

Full Name:_____Date of Birth _____

Marital Status (circle) Single Married Divorced Widowed

Address_____Apt#_____

City_____State_____Zip_____

Phone Number: Home_____ Cell_____

Email_____

Employer_____Employer Phone_____

Do we have your permission to leave a message at your ❑ Cell ❑ Home ❑ Work

PBM (Pharmacy Benefits Manager) Consent

This consent allows us to electronically send the medications to the pharmacy of your choice.
This consent also allows us to access medications that other physicians have prescribed, which may interact with new prescriptions you may be receiving.

Pharmacy Information

Pharmacy Name_____Phone_____Fax_____

Pharmacy Address_____

Emergency Contact Information:

Name_____Relationship_____Phone_____

Primary Insurance

Name of Policy Holder _____

Date of Birth of Policy Holder _____

Relationship to Patient _____

Patient/Guarantor Signature _____**Date** _____

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. I authorize the release of medical information to my primary care or referring physician and as necessary to process insurance claims, insurance applications, prior authorizations, pre certifications and prescriptions. I also authorize payment of medical benefits to the physicians. I also, authorize fax transmittal of my medical records, if necessary.

2. I am ultimately responsible for payment of charges for services I receive in your office. Any check payment dishonored by my bank will result in a $25.00 returned check charge added to my account.

3. It is my responsibility to provide the office with my current address, telephone number and insurance information.

4. It is my responsibility to contact my insurance carrier to confirm that the providers participate with my plan. If I see a doctor that is not currently on my plan, I will be responsible for payment in full.

5. If I do not provide correct insurance information (correct primary insurance) I will be responsible for payment in full.

6. If my plan requires a referral it is my responsibility to obtain this prior to being seen by the doctor. If the office is required to obtain the referral for you, please notify our office 72 hours prior so that we have ample time to acquire this information from your insurance company.

7. Co-payment, co-insurance and / or deductible not satisfied is due at the time of service.

8. Laboratory services will be provided by a contracted outside reference lab. Lab charges not covered by your medical insurance will be billed to you. Please contact the number on these invoices for any questions. I accept responsibility for valid lab charges not covered by my medical insurance plan. We cannot give you lab benefits or estimate of the cost of lab services. This must be obtained from the lab and/or your insurance carrier.

9. All medical records request must be in writing and received in our office 72 hours prior to the date needed. Medical release forms are available on our web site, www.Obgynofatlanta.com

10. If my account is referred to an outside collection agency this will result in termination of medical care and will be subject to a collection fee of up to 25%. This will be added to the total balance due at the time the account is turned over to a collection agency.

Your signature below signifies your understanding and willingness to comply with these policies.

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: _____

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:

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? ❑Yes ❑ No	
❑ Condoms	❑ Nuvaring
❑ Depo Provera	❑ Birth Control Patch
❑ Diaphragm	❑None
❑ IUD - Kind	❑ Natural Family Plan / Rhythm
- Date Inserted:	❑ Tubal Ligation
❑ Birth Control Pill	❑ Vasectomy
- Name:	❑ Withdrawal
❑ Contraceptive Foam / Jelly	❑ 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: ❑ Light ❑ Medium ❑ Heavy	
Do you have clots? ❑ Yes ❑ No	Do you have bleeding between periods? ❑ Yes ❑ No	
Do you have cramps? ❑ No ❑ mild ❑ moderate ❑ severe	Do you have pelvic pain at other times? ❑Yes ❑No	
Have you gone thru Menopause ❑ Yes ❑ 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 ❑ Yes ❑ No

Do you do a Self Breast Exam ❑ Yes ❑ No

Do you Drink Milk ❑ Yes ❑ No
Glasses per day:

Do you eat cheese or other dairy products ❑ Yes ❑ No
Servings per day:

Do you Take Calcium ❑ Yes ❑ No
Name and Dosage:

Do you Exercise
❑ None ❑ Less than 3 times per week ❑ More than 3 times per week

Are you Sexually Active ❑ Yes ❑ No
Do you have sex with? ❑ Husband ❑ Men ❑ Women ❑ Both

New sexual partner? ❑ Yes ❑ No How long? First Intercourse at Age: _____

Lifetime sexual partners ❑ Husband ❑ Less than 5 ❑ More than 5

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Engaged

Smoking ❑ Yes ❑ No
Packs per day: _____ Number of Years: _____

Alcohol ❑ Yes ❑ No
Drinks per day: _____ Drinks per week: _____

Drug User ❑ Yes ❑ No
Kind: Frequency: _____

History of abuse ❑ Yes ❑ No
❑ Physical ❑ Emotional ❑ Sexual

List all Natural or Herbal remedies, over the counter drugs, vitamins or minerals you are taking List:

Occupation:

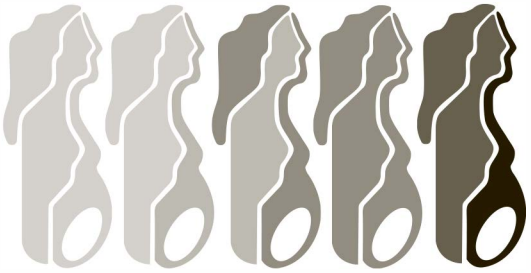
Race ❑ White ❑ African/American ❑ Hispanic ❑ Asian ❑ Other _____

NAME: _____ BIRTHDATE: _____/_____/_____

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

CONSTITUTIONAL		**NOTES**
Weight Loss	❑	
Weight Gain	❑	
Fever	❑	
Fatigue	❑	
Night Sweats	❑	
Hot Flashes	❑	
EYES		
Double vision	❑	
Vision changes	❑	
HENT		
Headaches	❑	
Dizziness	❑	
Sore Throat	❑	
Sinus Pain	❑	
Nose Bleeding	❑	
Thyroid Mass	❑	
Neck Pain	❑	
BREAST		
Lumps	❑	
Tenderness	❑	
Swelling	❑	
Discharge	❑	
Pain in Breast	❑	
Abn Changes in Breast	❑	
CARDIOVASCULAR		
Chest Pain	❑	
Irregular Heart Beats	❑	
Rapid Heart Rate	❑	
Fainting	❑	
Swelling of legs	❑	
Varicose veins	❑	
RESPIRATORY		
Wheezing	❑	
Cough	❑	
Shortness of breath	❑	
Spitting up blood	❑	
GASTROINTESTINAL		
Nausea	❑	
Vomiting	❑	
Diarrhea	❑	
Constipation	❑	
Abdominal Pain	❑	
Bloody / Black Stool	❑	
Hemorrhoids	❑	
Jaundice	❑	
GENITOURINARY		
Urgency of urination	❑	
Frequency of urination	❑	
Pain with urination	❑	
Nighttime urination	❑	
Losing urine	❑	
Blood in urine	❑	

GENITOURINARY (CONT)		**NOTES**
Decreased sex drive	❑	
Painful intercourse	❑	
Possible Pregnancy	❑	
Genital Sores	❑	
Vaginal discharge	❑	
SKIN		
Rashes	❑	
Itching	❑	
Skin Dryness	❑	
Skin Lesions	❑	
Changes to Lesions or Moles	❑	
Acne	❑	
NEUROLOGICAL		
Muscular Weakness	❑	
Numbness or Tingling	❑	
Difficulty Concentrating	❑	
Memory Difficulties	❑	
Speech Difficulties	❑	
Seizures	❑	
Loss of Balance	❑	
MUSCULOSKELETAL		
Joint Pain or Swelling	❑	
Muscle Pain	❑	
Back Pain	❑	
ENDOCRINE		
Loss of Hair	❑	
Difficulty Tolerating Cold	❑	
Difficulty Tolerating Heat	❑	
PSYCHIATRIC		
Anxiety	❑	
Depression	❑	
Impulsive Behavior	❑	
Suicidal Thoughts	❑	
Excessive Anger	❑	
Mood Swings	❑	
Emotional Abuse	❑	
Physical Abuse	❑	
Sexual Abuse	❑	
HEMATOLOGIC / LYMPHATIC		
Bruises, frequent or easily	❑	
Cuts do not stop bleeding	❑	
Enlarged lymph nodes	❑	
ALLERGIC / IMMUNOLOGIC		
Frequent illness	❑	
Seasonal Allergies	❑	
OTHER		
1	❑	
2	❑	
3	❑	



OBSTETRICS & GYNECOLOGY OF ATLANTA

Ob/Gyn
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Jennifer A. Loehle, M.D.
Kristen H. Lady, M.D.

Nurse Practitioners
Jennifer McKinney, CWHNP

Nurse Midwives
Kristy Bedell, CNM
Nicole Robinson, CNM
Holly Mitchell, CNM
Rhonda Massey, CNM
Jennifer Afman, CNM
Katie Morgan, CNM
Mitra Davis, CNM
Kylie-Ann Hamilton, CNM

Authorization to Release Medical Information

Phone 404-252-1137 Fax 866-912-2454

PatientName (Print): _____
Current Address: _____
Home #: _____ *Cell #:* _____ *Date of Birth:* _____

Who has the information you would like released?
Dr. Name: _____ *BusinessName:* _____
Address: _____ *Ste. #* _____ *City:* _____ *State:* _____ *Zip:* _____
Phone #: _____ *Fax #:* _____

To Whom should the information be sent?
Name: _____ *BusinessName:* _____
Address: _____ *Ste. #* _____ *City:* _____ *State:* _____ *Zip:* _____
Phone #: _____ *Fax #:* _____

Reason for Request:
☐ *Selected new physician in the area* ☐ *Second opinion I 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 obtainedfrom me or unless such disclosure is specifically required or permitted by law.*

Notice: *Unless specified below, this authorization is forfull disclosure of all records, including clinicalfindings, diagnoses, treatments, assessments, recommendations forfurther 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 I Psychiatric* _____ *Sexually Transmitted Disease* _____ *HIV/ AIDS*

This authorization is valid for one year or until _____ *, whichever comesfirst.*

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.