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** ______________________________

BP:_____ / _____
Wt:____________
Ht:____________

Date:_______ Name:______________________________________ Age______ D.O.B.__________
What are you scheduled for today? *(Check all that apply)*
☐ Annual Exam ☐ Mammogram ☐ Ultrasound ☐ Bone Density

Reason for today's visit:____
Any new gynecological problems?____
Date last period began:___________________ Allergies:____________________________________
Period: ☐ regular ☐ irregular Flow: ☐ normal ☐ heavy ☐ light Clots: ☐ yes ☐ no

☐ Married ☐ Single ☐ Heterosexual ☐ Lesbian
Women who are not in a mutually monogamous relationship or who have had more than one sex partner in the last year or who are under the age of 25 and have ever been sexually active should undergo annual screening for sexually transmitted diseases (STD).
Would you like STD testing at this visit? ☐ yes ☐ no

How many times have you been Pregnant?_______ How many children do you have?_______
Are you trying to avoid pregnancy? ☐ yes ☐ no If you are preventing pregnancy, which method are you using?___________________________ *(Please include brand of OCPS/IUD/sterilization method if appropriate)*

Vaccinations/Boosters: ***At today's visit, we will offer you vaccinations if you are not up-to-date.*** Which of the following vaccinations have you already received?
☐ Hepatitis A ☐ Tdap *(tetanus & whooping cough)* booster ☐ flu shot for the current flu season
☐ Hepatitis B ☐ If under 25, cervical cancer vaccination *(Gardasil)*

Are you under the care of another physician/PCP for a medical condition? ☐ yes ☐ no
Provider name/speciality: ____
Condition(s):____
All current Medications *(Please include dosages)*:______________________________________
____
Past Gyn Surgeries:____
Mammograms are recommended for women over age 40 and colonoscopy is recommended for women over age 50. Women with first-degree relatives with colon and/or breast cancer may need earlier screening.
When was you last Mammogram? __________
When was your last Colonoscopy? __________
Have you had a Bone Density Test? ☐ yes ☐ no when:___________
Do you have a family history of ☐ breast, ☐ ovarian, or ☐ colon cancer? ☐ osteoporosis?
Detail:____
Do you smoke? ☐ yes,______ cigs/day ☐ no Do you drink alcohol? ☐ yes,______ drinks/week ☐ no

Screening for Cervical cancer is changing and it depends on your pap smear history. Have you ever had an abnormal pap smear? ☐ yes ☐ no. If yes, how severe was the abnormality:_____________________________
What did you have done to treat this? *(Check all that apply)* ☐ Colposcopy ☐ TCA acid/freezing
☐ LEEP/cone more frequent pap smears ☐ the abnormal cells got better without treatment.
How long ago did this happen? ☐ more than 20 years ago ☐ less than 20 years ago

If you have a healthy immune system and have never had an abnormal pap smear please see below for current American College of OB-GYN recommendations: You still need an annual pelvic exam.
- ***Under age 21 do not need a pap smear regardless of sexual activity***
- ***21-29: pap smear every 3 years*** • ***30-65: Pap and HPV every 3-5 years.***
- ***no screening for women >65 and women who have had a hysterectomy with removal of their cervix***

Have you had cholesterol/glucose screening in the last 5 years? ☐ yes ☐ no
Are you fasting today? ☐ yes ☐ no
Please describe any changes in personal, social or health status since your last visit:_________________________
____

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
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	❑	