WELCOME TO THE WOMEN'S GROUP OF GWINNETT, P.C.

Please print and complete the necessary forms before your scheduled visit. We recommend you arrive at least twenty minutes prior to your scheduled appointment with these forms **completed**. Having all paperwork completed at the time of your arrival helps us provide quality care in a timely fashion. **PLEASE BE SURE TO BRING YOUR INSURANCE CARD AND PHOTO I.D. IF YOU WERE REFERRED BY ANOTHER PHYSICIAN, PLEASE BRING ANY RECORDS FROM THE REFERRING PHYSICIAN.**

In the practice of obstetrics and gynecology, emergencies arise that interrupt the normal flow of the office practice which may cause us to run behind. We appreciate your patience and understanding.

Thank you.

William D. Haberstroh, D.O.
A.Neil Harrison, M.D.
Sabrina O. Falkner, M.D.
Yolonda M. Smith, M.D.
Kimberly A. Huynh, M.D.
Melissa O. Iyoyo, M.D.
Anna R. Pollard, WHNP-BC

To: All OB Patients

From: The Women's Group of Gwinnett, P.C.

When you come for your first OB visit, you will need to bring all insurance cards. It is imperative that you give us the information regarding all insurance coverage. Failure to do so may result in your being responsible for the entire payment of all charges.

If you have coverage through your employer and are covered by your spouse's insurance, according to the law your insurance will always be primary. Also, if you have Medicaid, your insurance would be primary and Medicaid secondary.

If your insurance coverage changes during your pregnancy, please let us know immediately.

PATIENT REGISTRATION & HEALTH QUESTIONNAIRE-PLEASE PRINT
***This form is to be completed annually**

NAME____NICK NAME______________DATE OF BIRTH____________________

MARITAL STATUS: (circle one) M S D W

STREET ADDRESS:___________________________________APT#________CITY.ST.ZIP____________________________________

PHONE: HOME________________WORK__________________EMPLOYER____

CELL PHONE__________________SS#________________________REFERRED BY:____

SPOUSE'S NAME_________________________DATE OF BIRTH______________SS#____

EMPLOYER_________________________________CELL PHONE____________________ WORK PHONE______________________

IF UNDER 18-PARENT/GUARDIAN____

EMERGENCY CONTACT (other than spouse)_________________________PHONE____

PLEASE LIST ANY ALLERGIES OR DRUG SENSITIVITIES____

PHARMACY PHONE # AND ADDRESS____

DO YOU GIVE US PERMISSION TO RECEIVE HISTORY FROM PHARMACY & SEND PRESCRIPTIONS TO THEM? _______________________

INSURANCE & BILLING INFORMATION

PRIMARY INSURANCE CO:____________________________GROUP #______________ID#_____________________________________

NAME OF INSURED________________________RELATIONSHIP TO PT_________DATE OF BIRTH________SS#_____________________

SECONDARY INSURANCE CO:___________________________GROUP #____________ID#______________________________________

NAME OF INSURED________________________RELATIONSHIP TO PT_________DATE OF BIRTH_________SS#____________________

NAME & ADDRESS OF PERSON RESPONSIBLE FOR BILL____

____

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and family physicians and to my insurance co.
I allow fax transmittal of my medical records, if necessary
I acknowledge full financial responsibility for services rendered by The Women's Group of Gwinnett, P.C.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
I further authorize and request that insurance payments be made directly to the named provider.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.
Medical records consist of confidential information relating to your health. It is the policy of The Women's Group of Gwinnett, P.C. not to release medical records without the patient's prior written consent. I understand that any request for release of such medical records must be in writing at the time of such request.

Signature____Date________________________________

PARENT/GUARDIAN (age 16 & under)________________________ __________________________________
Printed Signature

OFFICE POLICY ON MANAGED CARE INSURERS

IN ORDER TO ACCOMMODATE THE NEEDS AND REQUESTS OF OUR PATIENTS WE HAVE ENROLLED IN NUMEROUS MANAGED CARE INSURANCE PROGRAMS.

WHILE WE ARE PLEASED TO BE ABLE TO PROVIDE THIS SERVICE TO YOU, IT IS EXTREMELY DIFFICULT FOR US TO KNOW ALL THE INDIVIDUAL REQUIREMENTS OF THE PLANS. EACH ONE HAS DIFFERENT STIPULATIONS REGARDING HOW OFTEN SERVICES MAY BE PERFORMED.

EVEN WITH THE SAME INSURANCE COMPANY THE PLANS DIFFER DEPENDING UPON WHAT TYPE OF CONTRACT YOUR EMPLOYER HAS NEGOTIATED.

PROVIDING QUALITY MEDICAL CARE FOR OUR PATIENTS IS OUR PRIMARY CONCERN; WE ARE MORE THAN WILLING TO PROVIDE THAT CARE WITHIN YOUR INSURANCE CONTRACT GUIDELINES IF YOU LET US KNOW AT EACH TIME OF SERVICE WHAT THOSE GUIDELINES ARE.

UNFORTUNATELY, IF YOU DO NOT INFORM US OF ANY SPECIAL REQUIREMENTS IN YOUR CONTRACT AND WE SUBSEQUENTLY ORDER SERVICES, SUCH AS LAB WORK OR HOSPITALIZATION, THAT ARE NOT COVERED AT THE SELECTED MEDICAL FACILITY, WE WILL HAVE NO CHOICE BUT TO BILL YOU DIRECTLY FOR THOSE CHARGES. PAYMENT FOR THOSE CHARGES IS THEN YOUR RESPONSIBILITY.

ALSO, ANY SERVICES NOT COVERED BY YOUR INSURANCE WILL BE YOUR RESPONSIBILITY.

IF SERVICES ARE PROVIDED AND YOUR COVERAGE IS NOT IN EFFECT ON THAT DAY, THE FEES SUBMITTED AND DENIED BY YOUR CARRIER WILL BECOME YOUR RESPONSIBILITY.

WITH YOUR COOPERATION AND HELP, YOU SHOULD BE ABLE TO RECEIVE ALL OF THE BENEFITS OFFERED TO YOU, AND WE WILL BE ABLE TO CONCENTRATE ON CARING FOR YOUR MEDICAL NEEDS.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

______________________________	______________________________
PATIENT AND/OR INSURED	DATE

THE WOMEN'S GROUP OF GWINNETT, P.C.
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I___________________________________have been informed that a copy of **THE WOMEN'S GROUP OF GWINNETT, P.C.** Notice of Privacy Practices is posted on their web site and in the office.

____ ________________________
Signature Date

It is our policy not to release confidential and/or unauthorized information by home telephone answering machine, work telephone, voice mail or cell phone. However, we will confirm appointments by telephone. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residency. Information will also not be left with an unauthorized person who may answer the telephone.

Health History Summary

Date: mo / day / hr.

THE WOMEN'S GROUP OF GWINNETT, P.C.

(770) 979-4700

PATIENT IDENTIFICATION

Patient's Name_______________

Home Address_______________
STREET
____
CITY STATE ZIP

Age_____ | Date of Birth mo / day / yr | Race or Ethnicity_____ | Religion_____ | Marital status_____ | Years married_____ | Education_____

Social Security Number_______________ | Occupation_______________ | Work Tel. No._____ | Home Tel. No._____

Alternate Contact_______________ | Relation to Patient_______________ | Work Tel. No._____ | Home Tel. No._____

Referring Physician_______________ | Attending Physician_______________ | OPTIONAL FOR INSURANCE, ETC.

Medical History

Check and detail positive findings including date and place of treatment. Precede by reference number.

No.	Condition	Patient	Family	Details
1.	Congenital anomalies………………………….	☐	☐	
2.	Genetic diseases…………………………….	☐	☐	
3.	Multiple births……………………………….	☐	☐	
4.	Diabetes mellitus…………………………….	☐	☐	
5.	Malignancies………………………………….	☐	☐	
6.	Hypertension………………………………….	☐	☐	
7.	Heart disease………………………………….	☐	☐	
8.	Rheumatic fever………………………………	☐	☐	
9.	Pulmonary disease………………………….	☐	☐	
10.	GI problems………………………………….	☐	☐	
11.	Renal disease……………………………….	☐	☐	
12.	Genitourinary tract problems……………….	☐	☐	
13.	Abnormal uterine bleeding………………….	☐	☐	
14.	Infertility………………………………………	☐	☐	
15.	Venereal disease…………………………….	☐	☐	
16.	Phlebitis, varicosities……………………….	☐	☐	
17.	Neurologic disorders……………………….	☐	☐	
18.	Metabol./endocrine disorders……………….	☐	☐	
19,	Anemia/hemoglobinopathy………………….	☐	☐	
20.	Blood disorders………………………………	☐	☐	
21.	Drug abuse……………………………………	☐	☐	
22.	Smoking/alcohol use……………………….	☐	☐	
23.	Infectious diseases………………………….	☐	☐	
24.	Operations/accidents……………………….	☐	☐	
25.	Allergies/meds sensitivity………………….	☐	☐	
26.	Blood transfusions………………………….	☐	☐	
27.	Other hospitalizations……………………….	☐	☐	
28.	_______________	☐	☐	
29.	_______________	☐	☐	
30.	**No known disease/problems……………..**	☐	☐	

Preexisting Risk Guide

Indicates pregnancy/outcome at risk

31. ☐ Age < 15 or > 35
32. ☐ <8th grade education
33. ☐ Cardiac disease (class 1 or II)
34. ☐ Tuberculosis, active
35. ☐ Chronic pulmonary disease
36. ☐ Thrombophlebitis
37. ☐ Endocrinopathy
38. ☐ Epilepsy (on medication)
39. ☐ Infertility (treated)
40. ☐ 2 abortions (spontaneous/induced)
41. ☐ > 7 deliveries
42. ☐ Previous preterm or SGA infants
43. ☐ Infants > 4,000 gms
44. ☐ Isoimmunization (ABO, etc.)
45. ☐ Hemorrhage during previous preg.
46. ☐ Previous preeclampsia
47. ☐ Surgically scarred uterus
48. ☐ Preg. Without familial support
49. ☐ Second pregnancy in 12 months
50. ☐ Smoking (> 1 pack per day)
51. ☐ _______________
52. ☐ _______________
53. ☐ _______________

Indicates pregnancy/outcome at **high** risk

54. ☐ Age > 40
55. ☐ Diabetes mellitus
56. ☐ Hypertension
57. ☐ Cardiac disease (class III or IV)
58. ☐ Chronic renal disease
59. ☐ Congenital/chromosomal anomalies
60. ☐ Hemoglobinopathies
61. ☐ Isoimmunization (Rh)
62. ☐ Alcohol or drug abuse
63. ☐ Habitual abortions
64. ☐ Incompetent cervix
65. ☐ Prior fetal or neonatal death
66. ☐ Prior neurologically damaged infant
67. ☐ Significant social problems
68. ☐ _______________
69. ☐ _______________
70. ☐ _______________

Menstrual History

Onset	Cycle	Length	Amount	LMP
age	q. days	age	age	mo / day / yr quality

Pregnancy History

Grav	Term	Pret	Abort	Live	EDC
					mo / day / yr quality

No.	Month/ year	Sex	Weight at Birth	Wks. gest.	Hrs. in labor	Type of delivery	Details of delivery: include anesthesia and maternal or newborn complications. Use Risk Guide numbers where applicable.
1							
2							
3							
4							
5							
6							
7							
8							

Historical Risk Status

71. ☐ No risk factors noted
72. ☐ At risk
73. ☐ At **high** risk

Signature

PRENATAL GENETIC QUESTIONNAIRE

Please take time to answer the following questions as thoroughly as possible. The answers you provide will help your physician and genetic counselor identify any potential inherited or exposure-related risks to your unborn baby.

PATIENT NAME__________________________________ PHYSICIAN___________________

1. Will you be 35 years or older when your baby is born Yes ☐ No ☐

2. Do you or the baby's father have a birth defect? Yes ☐ No ☐
*if yes, please indicate:*___________________________________

3. Do you have a child with a major birth defect or problem? Yes ☐ No ☐
*if yes, please explain:*____________________________________

4. Have any of the following occurred in your family or in the baby's father's family?

Bleeding disorder (e.g. hemophilia)	Yes ☐	No ☐
Cystic fibrosis	Yes ☐	No ☐
Muscular dystrophy	Yes ☐	No ☐
Spina bifida or anencephaly	Yes ☐	No ☐
Hydrocephaly	Yes ☐	No ☐
Down syndrome or another syndrome	Yes ☐	No ☐
Other chromosomal abnormality	Yes ☐	No ☐
History of two or more miscarriages (indicate #)	Yes ☐	No ☐
Heart defect	Yes ☐	No ☐
Severe anemia	Yes ☐	No ☐
Congenital kidney or liver disease	Yes ☐	No ☐
Enzyme deficiency (e.g. PKU)	Yes ☐	No ☐
Huntington's Disease	Yes ☐	No ☐
Neurofibromatosis	Yes ☐	No ☐
Tumors of the eye (retinoblastoma)	Yes ☐	No ☐

If yes, please indicate relationship of the affected person to you or the baby's father.

5. Do any close relatives in either your family or the baby's father's family have a familial disorder not listed above? Yes ☐ No ☐
if yes, please explain:

6. Do you or the baby's father have any close relatives with mental retardation?
Yes ☐ No ☐

If yes, please indicate relationship of the affected person to you or the baby's father, and the cause (if known):

7. Are you and the baby's father related to each other in any way (e.g. cousins)?
Yes ☐ No ☐

if yes, please explain:

A number of genetic diseases occur more commonly in certain ethnic groups. For this reason, it is important that we know your ethnic background.

8. Are you or the baby's father of Jewish or French-Canadian ancestry? Yes ☐ No ☐
if yes, indicate who and the ancestry:

Have either of you been screened for Tay-Sachs disease? Yes ☐ No ☐
if yes, indicate who and the results:

9. Are your or the baby's father of Black, Hispanic, Asian or Mediterranean ancestry? Yes ☐ No ☐

if yes, indicate who and the ancestry:

Have either of you been screened for sickle cell trait? Yes ☐ No ☐

if yes, indicate who and the results:

10. Are you or the baby's father of Philippine or Southeast Asian ancestry? Yes ☐ No ☐

if yes, indicate who and the ancestry:

Have either of you been tested to determine if you are carriers of Alpha-thalassemia, a blood disorder? Yes ☐ No ☐

if yes, indicate who and the results:

11. Do you have a chronic medical condition, such as diabetes, PKU or a thyroid problem? Yes ☐ No ☐

if yes, list diagnosis:

12. Have you taken any medication during this pregnancy? Yes ☐ No ☐
if yes, give name of medication and time taken during pregnancy:

13. During this pregnancy have you:

Had exposure to x-rays?	Yes ☐	No ☐
Had exposure to contagious illnesses?	Yes ☐	No ☐
Had any alcohol to drink?	Yes ☐	No ☐
Smoked any cigarettes?	Yes ☐	No ☐
Used any "recreational" drugs?	Yes ☐	No ☐

14. Do you have any history of Beta strep infection in pregnancy? Yes ☐ No ☐

Good prenatal care depends on open communication. Please read the accompanying pamphlet and notify your physician if you recall or realize any new information about your family.

Provided as a courtesy to the medical genetics community by Integrated Genetics

THE WOMEN'S GROUP OF GWINNETT, P.C.

MEDICATION PRESCRIPTION POLICY

The physicians at The Women's Group of Gwinnett are happy to help you with your prescription needs. This includes supplying needed medication for our patients. We do have certain guidelines for refilling your medications prescribed by our physicians.

1. If you need a refill on your medication, we ask that you call your pharmacy at least 5-7 days prior to your refill and tell them which medication you need refilled. They in turn will contact us with all of the information we need to be able to refill the medicine.

2. **We do not refill medication after business hours or on weekends.** Our physicians do not have access to your medical records after business hours. Please make sure you contact your pharmacy before you take all your medication to allow time for the refill to be processed. All refills are authorized by the physician, so we must have ample time to contact the physician for authorization.

3. Any calls for medication received after 3:00 PM will not be addressed until the following business day. **If you call the answering service after hours for medication refills, the physician on call will not be paged.**

4. It is the policy of this office that a patient only receives narcotics from one treating physician. If you are receiving narcotic medications from another physician, we will not prescribe these for you.

I have read and understand the above policy on medication refills.

Patient name: please print____

Patient signature:____Date:____________________

ACCEPTANCE OF BLOOD PRODUCTS

At The Women's Group of Gwinnett we strive for optimum health and to preserve life. In the case of a life threatening emergency, **it is our policy to transfuse with blood if it is necessary to save your life.**

Please sign one of the below:

I understand and **agree** with the above transfusion policy.

Signature Date

I **disagree** and will be transferring my care elsewhere.

Signature Date

____

Witness signature Date

The Women's Group of Gwinnett, P.C.
1700 Tree Lane Rd.
Suite 230
Snellville, GA 30078

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize The Women's Group of Gwinnett to contact me at the following places:

Home telephone/answering machine	yes	no
Cell phone/voice mail	yes	no
Work telephone	yes	no

_____________You may discuss my medical information ONLY with me

_____________ I give my permission to discuss my medical information with the following people:

__________________________________Relationship_______________

__________________________________Relationship_______________

__________________________________Relationship_______________

Please list names of people with whom we may discuss your financial information:

___________________________________Relationship_______________

___________________________________Relationship_______________

YES or **NO** You may leave medical information (test results) on my voice mail at:

Cell #__________________________ Home #___________________________

____
Name: please print

____ __________________________
Signature of Patient/Guardian Date: