PATIENT REGISTRATION & HEALTH QUESTIONNAIRE – PLEASE PRINT

THIS FORM IS TO BE COMPLETED ANNUALLY

NAME: _____ PREFFERED NAME: _____

DATE OF BIRTH: ____ /____ /_____ MARITAL STATUS (*circle one*): M S D W ETHNICITY: _____

EMAIL: _____ REFFERED BY: _____

ADDRESS: _____APT#: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: HOME-_____ CELL-_____WORK-_____

SS#: ____-_____-_____ IF UNDER 18, PARENT/GUARDIAN: _____

EMERGENCY CONTACT: _____PHONE #: _____

PLEASE LIST ANY ALLERGIES OR DRUG SENSITIVITIES: _____

PHARMACY (*name, address & phone #*) _____

DO YOU GIVE US PERMISSION TO RECEIVE HISTORY FROM PHARMACY & SEND PRESCRIPTIONS TO THEM? YES or NO

INSURANCE & BILLING INFORMATION

PRIMARY INSURANCE CO: _____ NAME OF INSURED: _____

RELATIONSHIP TO PATIENT_____ DATE OF BIRTH: ____ /___ /_____ SS# : _____-_____-_____

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 primary care physician and to my insurance co. I will 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. There will be a $30.00 returned check fee. 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 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 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 (*if under 18*) PRINT SIGNATURE

OB/GYN PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Date of Birth: ____ /____ /_____

Main reason for today's visit? _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Long-term relationship ☐Widowed

MENSTRUAL HISTORY

(complete even if post-menopausal or no longer having periods)

- Age of first period: _____years.
- If your menstrual periods are regular; period start every: _____ days.
- If your menstrual is irregular; period starts every: _____ to _____ days. (e.g., 12 to 60)
- Duration of bleeding: _____ days. Clots? ☐Yes ☐No
- Does bleeding or spotting occur between periods? ☐Yes ☐No
- Does bleeding or spotting occur after intercourse? ☐Yes ☐No
- First day of last menstrual period: _____
- Is pain associated with periods? ☐Yes ☐No ☐Occasionally
- If yes, is it: ☐Before menses ☐During menses ☐Both
- What birth control method(s) do you currently use? _____

PREGNANCY HISTORY (ALL PREGNANCIES)

(Obstetrical history including abortions & ectopic [tubal] pregnancies)

Date of Delivery	Duration of Pregnancy Full Term 37-41wks Preterm <37wks	Type of Delivery Vaginal, C-section or Vacuum	Note Complications Mother and/or Infant • Preeclampsia • Gestational Diabetes • Premature Labor • Other/Specify	Child's Sex	Child's Birth Weight	Anesthesia Epidural Spinal General Local None?

TOTAL NUMBER OF PREGNANCIES? _____ MISCARRIAGES? _____ TERMINATIONS? _____

PAST SURGICAL HISTORY (NOT OB/GYN): List all surgeries and their years or ☐None

Surgery	Mo/Year

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PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES: Check any that apply or ☐None

SURGERY	YEAR	SURGERY	YEAR
☐D&C		☐Ovarian Surgery	
☐Hysteroscopy		☐L Cyst(s) removed ovarian	
☐Infertility Surgery		☐R Cyst(s) removed ovarian	
☐Tubal Ligation		☐L ovary removed	
☐Laparoscopy		☐R ovary removed	
☐Hysterectomy (Vaginal)		☐Vaginal or bladder repair for prolapse or incontinence	
☐Hysterectomy (Abdominal)		☐Cesarean section	
☐Myomectomy		☐ Other (specify)_____	

PAP SMEAR/MAMMOGRAM HISTORY

- Date of last pap smear: _____: ☐Normal ☐Abnormal
- Have you had abnormal pap smears? ☐Yes ☐No
- Have you had treatment for abnormal pap smears? ☐Yes ☐No
- If yes, what type(s) of treatment have you had?
  - ☐ Colposcopy ☐ Cone Biopsy
  - ☐ Cryotherapy ☐ Loop Excision (LEEP)
- Date of last mammogram: _____
- Have you had an abnormal mammogram? ☐Yes ☐No

OTHER PAST GYNECOLOGICAL HISTORY: Check any that apply or ☐None

☐VENEREAL WARTS ☐HERPES-GENITAL ☐PELVIC INFLAMMATORY DISEASE ☐PCOS
☐ENDOMETRIOSIS ☐CHLAMYDIA ☐POST MENOPAUSAL BLEEDING ☐POST MENOPAUSAL
☐HPV ☐SYPHILIS ☐HIV
☐FIBROIDS ☐GONORRHEA ☐OTHER (SPECIFY) _____

CURRENT MEDICATIONS (include dose/amount per day)

MEDICATION	DOSE	MEDICATION	DOSE

DRUG ALLERGIES: ☐NO ☐YES, LIST NAME & REACTION

DRUG	REACTION

Women's Group of Gwinnett

PAST MEDICAL HISTORY: Check any that apply or ☐None

☐ARTHRITIS
☐HIGH BLOOD PRESSURE
☐BREAST CANCER
☐DIABETES
☐ DIET CONTROLLED
☐ PILL CONTROLLED
☐INSULIN CONTROLLED
☐GESTATIONAL
☐HEART CONDITION (SPECIFY)_____
_____
_____
☐SKIN CONDITION (SPECIFY)_____
_____
_____

☐KIDNEY DISEASE
☐ASTHMA
☐ANXIETY
☐BIPOLAR
☐DEPRESSION
☐MIGRAINES
☐HEMERRHOIDS
☐HIV+
☐BLOOD TRANSFUSIONS
☐BLOOD CLOTS LEG/THIGH/PULMONARY
☐OSTEOPENIA/OSTEOPOROSIS
☐CANCER (SPECIFY)_____
_____
_____

☐THYROID DISEASE
☐ HYPOTHYROIDISM
☐HYPERTHYROIDISM
☐HEPATITIS, LIVER DISEASE
☐OTHER (SPECIFY)_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

DO YOU CURRENTLY?

SMOKING:	☐ Never ☐ Former	☐ Yes, Packs/Day: _____ Years Smoked? _____ Age Stopped? _____	☐ Cigarettes ☐ Vape ☐ Hookah
ALCOHOL:	☐ Never	☐ Former	☐ Yes, Drinks/Week _____
ILLICIT DRUGS:	☐ Never	☐ Former	Yes, Type: _____
EXERCISE REGULARLY:	☐ No	☐ Yes	Days/Week _____

FAMILY HISTORY or ☐None

	Yes	Estimate age at Diagnosis	Affected Relatives (Father, Mother, Brother, Sister, Son, Daughter, MGM, PGM, MGF, PGF)
DIABETES			
OVARIAN CANCER			
HEART DISEASE			
ENDOMETRIAL CANCER			
BREAST CANCER			
COLON CANCER			

Have you had genetic screening, such as BRCA? ☐Yes ☐No

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 plan. Each one has different stipulations regarding how often services are 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 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

500 Medical Center Blvd, Suite 250. Lawrenceville, Georgia 30046
1120 Peachtree Industrial Blvd, Suite 209. Suwanee, Georgia 30024
Phone: 770-979-4700 Fax: 770-979-1060
www.womensgroupofgwinnett.com

SELECTION FORM FOR AUXILIARY AIDS AND SERVICES

To provide the best care to you during your visits at The Women's Group of Gwinnett, we ask that you complete the information requested below. We ask for this information so that we can effectively communicate with patients and family members/friends who are deaf or hard of hearing.

Are you or your family member/friend deaf or hard of hearing? **If no, sign below and return to a Women's Group of Gwinnett staff member.**

NO - _____ _____
Signature Date

YES – Complete the information below.

_____ _____
Name of Person with Disability Patient's Name

Relationship to Patient:

- ☐ Self
- ☐ Friend
- ☐ Family Member
- ☐ Other: _____

I or my companion will need the service(s) selected below to enable effective communications while at The Women's Group of Gwinnett. All interpreter services are provided FREE OF CHARGE.

Interpreter on-site (mark the type of interpreter needed)

- ☐ American Sign Language (ASL)
- ☐ Signed English
- ☐ Oral
- ☐ Paper and pen for writing notes
- ☐ TTYs for telephone communication
- ☐ Other: _____
- ☐ Nothing requested at this time.

PRACTICE PERSONNEL WILL ARRANGE SERVICES OF INTERPRETERS

In order to ensure that we meet your healthcare needs, it may be necessary to start treatment before the arrival of an on-site interpreter. If that happens do you want someone else to help with communication? If so, who? _____. We ask for your patience if it is necessary to use another form of communication in the event that emergency treatment is required.

If your needs change, please let your doctor or any employee of The Women's Group of Gwinnett know and we will make accommodations to assist you. If you need further assistance, please ask your doctor or other personnel.

_____ _____
Patient Signature WGG Employee

_____ _____
Date Date

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 your 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 medications 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 call for medication received after 3:00pm 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 medication from another physician, we will not prescribe these for you.

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

_____
Print Patient Name

_____ _____
Patient Signature Date

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AUTHORIZATION TO RELEASE PATIENT INFORMATION / HIPPA

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

- Home Telephone ◯Yes ◯No
- Cell Phone ◯Yes ◯No
- Work Telephone ◯Yes ◯No

◯Yes, you may leave medical information (such as test results) on my voicemail.

Cell #_____ Home #_____

◯No, you may **NOT** leave medical information on my voicemail.

◯You may discuss my **medical information** with ONLY me.

Please list the names of people with whom we may discuss your **medical information**:

_____ Relationship_____

_____ Relationship_____

◯You may discuss my **financial information** with ONLY me.

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

_____ Relationship_____

_____ Relationship_____

I have been informed that a copy of The Women's Group of Gwinnett, P.C. Notice of Privacy Practices is posted on their website and in office.

◯ No, I do not want a copy of the policy but I do acknowledge that it exists.

◯ Yes, I have requested and been given a copy of the privacy policy.

_____
Print Name

_____ _____
Signature of Patient/Guardian Date

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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 understand that if I am pregnant or needing surgery, I will not be able to keep my appointment.

_____

Signature Date

_____

Witness Signature Date

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