Women's Group of Gwinnett

OB/GYN QUESTIONNAIRE

Please answer all questions, if a question does not apply, place NA on that line.

NAME: _____ DATE: _____

- Please list the **ONE** main reason you need to be seen today **:** _____
- What is the first day of your last period? _____
- How many days does your cycle last, on average? _____ Is the flow: ☐Light ☐Medium ☐Heavy
- What method of birth control are you currently using?_____
- Are you postmenopausal? ☐Yes ☐No. If yes, what year did you transition?_____
- What medications are you currently taking, including over the counter medicines and vitamins?
  (Please include strength/dosage) _____
  _____
  _____
- Preferred pharmacy name and location:_____
- Please list any allergies or drug sensitivities AND what reaction occurred?
  _____
- Have you had a Mammogram since your last visit? ☐Yes ☐No. If yes, when? (month/year):_____
- Have you had a Colonoscopy since your last visit? ☐Yes ☐No. If yes, when? (month/year):_____
- Have you had any major illnesses, health changes or surgery, since your last visit? Please be specific.
  _____
  _____
- Have you had any changes in family health history, since your last visit? Please be specific. _____
  _____
- What is your current occupation/job title? _____
- Relationship Status:☐Single ☐Dating ☐Engaged ☐Married ☐Separated ☐Divorced ☐Widowed ☐Same-sex
- Alcohol Use: ☐Light ☐Heavy ☐Former ☐Never
- Tobacco Use: ☐Yes ☐Former ☐Never. If yes, how many per day? ____ If former, what age did you quit?_____
- Exercise: ☐Yes, how days per week?_____ ☐Sedentary ☐Active, but no formal exercise
- Do you desire STD screening with today's visit? ☐Yes ☐No

Women's Group of Gwinnett

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

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

CANCELLATION, NO-SHOW AND FINANCIAL POLICY

If you do not show up for your appointment AND if you did not cancel your appointment at least 24 hours in advance, Women's Group of Gwinnett, will charge you a "no-show fee." The amount of the no-show fee will depend on the nature of your scheduled visit. For example, missed office visits or annuals will result in a $25.00 no-show fee and missed procedures will result in a no-show fee of $50.00. A no-show fee is a separate charge that will not be covered by your insurance plan. After three no-show appointments, you may be discharged from the practice.

BEFORE CHARGING YOU A NO-SHOW FEE, WE MAY CONSIDER EXTENUATING CIRCUMSTANCES ON A CASE-BY-CASE BASIS.

You will need to pay the no-show fee in full before you are seen for any future appointments.

WHY WE CHARGE A NO-SHOW FEE: A patient who does not show up for their appointment and who had not cancelled their appointment with at least 24 hours advance notice affects the care we provide our other patients and the cost of care.

I understand the Women's Group of Gwinnett no-show, cancellation & financial policies and agree to pay the fees above if I am a no-show or do not call the office at least 24 hours in advance of my appointment to cancel.

I understand that the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment for all services rendered to patient herein.

PATIENT NAME (Please Print): _____

PATIENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____