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

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

OB/GYN PATIENT HEALTH HISTORY QUESTIONNAIRE

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

Main reason for today's visit? _____

MENSTRUAL HISTORY

- Age of first menstrual cycle: _____years old. Are you postmenopausal? _____. If yes, what year did you transition? _____.
- If your menstrual cycle is regular, your period starts every: _____ days.
- If your menstrual is irregular, your period starts every: _____ to _____ days. (e.g., 12 to 60)
- Duration of bleeding: _____ days. Is the flow: ☐light ☐medium ☐heavy
- Does bleeding or spotting occur between periods? ☐Yes ☐No, and/or after intercourse? ☐Yes ☐No
- Is pain associated with periods? ☐Yes ☐No, Do you experience large clots? ☐Yes ☐No
- First day of last menstrual period: _____
- 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 (Number of weeks) 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 (M/F)	Child's Birth Weight (lb, oz)	Anesthesia (Epidural, Spinal, General, Local Or None)	Location Of Delivery (which hospital)

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

PAP SMEAR/MAMMOGRAM/COLONOSCOPY/DEXA HISTORY

- Date of last pap smear: _____
- Have you had an abnormal pap smear? ☐Yes ☐No. If yes, what year(s)?_____
- Have you had treatment for an abnormal pap smear? ☐Yes ☐No
- If yes, what type(s) of treatment have you had?
  - ☐ Colposcopy, year? _____
  - ☐ Cryotherapy, year? _____
  - ☐ Cone Biopsy, year? _____
  - ☐ Loop Excision (LEEP), year? _____
- Date of last mammogram: _____
- Have you had an abnormal mammogram? ☐Yes ☐No If yes, what year(s)? _____
- Have you had a DEXA/Bone scan? ☐Yes ☐No If yes, what year(s)? _____
- Did they diagnose: ☐Osteoporosis ☐Osteopenia
- Have you had a Colonoscopy? ☐Yes ☐No If yes, what year(s)? _____. Was it normal? ☐Yes ☐No
- When is the next colonoscopy due? ☐1 yr ☐2yrs ☐5yrs ☐10yrs ☐Other:_____

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

☐CHLAMYDIA	☐HERPES-Type 2	☐PELVIC INFLAMMATORY DISEASE	☐PCOS
☐GONORRHEA	☐HERPES-Type 1	☐ENDOMETRIOSIS	☐FIBERCYSTIC BREAST TISSUE
☐HIV	☐HEPATITIS B or C	☐FIBROIDS	☐BREAST ABCESS
☐SYPHILIS	☐BICORNUATE UTERUS	☐POST MENOPAUSAL BLEEDING	☐VAGINAL PROLAPSE
☐HPV	☐DIDELPHIC UTERUS	☐INFERTILITY	☐VAGINITIS/BV/YEAST
☐VENEREAL WARTS	☐PMS/PMDD	☐OTHER (SPECIFY) _____	

- **HAVE YOU RECEIVED THE GARDASIL VACCINE?** (The series of 3 shots to prevent certain types of HPV)? ☐ YES ☐NO
- **DO YOU DESIRE STD SCREENING WITH TODAY'S VISIT?** ☐Yes ☐No

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

SURGERY	YEAR	SURGERY	YEAR
☐D&C		☐Endometrial biopsy	
☐Hysteroscopy		☐Left ovarian cyst(s) removed	
☐Infertility Surgery		☐Right ovarian cyst(s) removed	
☐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)_____	

PAST SURGICAL HISTORY (NON-OB/GYN): ☐None ☐YES, List all surgeries and the year of operation: _____

_____

_____

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

☐HIGH BLOOD PRESSURE
☐HIGH CHOLESTEROL
☐BREAST CANCER
☐DIABETES
- ☐DIET CONTROLLED
- ☐Rx CONTROLLED
- ☐INSULIN CONTROLLED
- ☐GESTATIONAL

☐HEMATURIA
☐HEART CONDITION (SPECIFY)_____
_____

☐ARTHRITIS
☐ASTHMA, yr of last known attack?_____
☐ANXIETY
☐BIPOLAR, Type 1 or Type 2? _____
☐DEPRESSION
☐MIGRAINES
☐HEMORRHOIDS
☐HIV+
☐BLOOD TRANSFUSION
☐BLOOD CLOTS (LEG/THIGH/PULMONARY)
☐KIDNEY DISEASE

☐THYROID DISEASE
- ☐HYPOTHYROIDISM
- ☐HYPERTHYROIDISM

☐HEPATITIS, LIVER DISEASE
☐GERD/ACID REFLUX
☐SKIN CONDITION:_____
☐CANCER (SPECIFY)_____
_____
☐OTHER (SPECIFY)_____
_____
_____

CURRENT MEDICATIONS (include dose/strength): _____

_____

Preferred pharmacy name and location:_____

DRUG ALLERGIES: ☐No Known ☐YES, List name AND reaction: _____

_____

CURRENT SOCIAL HISTORY:

Alcohol: ☐Light ☐Heavy ☐Former ☐Never

Tobacco: ☐Yes ☐Former ☐Never. If yes, how many per day? _____. If former, what age did you quit?_____

Exercise: ☐Yes, days per week?_____ ☐Sedentary ☐Active, but no formal exercise

WHAT IS YOUR CURRENT OCCUPATION/JOB TITLE? _____

Relationship Status: ☐Single ☐Dating ☐Engaged ☐Married ☐Separated ☐Divorced ☐Widowed ☐Same-sex

FAMILY HISTORY or ☐None/Unknown

	Yes or No	Affected Relatives w/ estimated age at diagnosis (Father, Mother, Brother, Sister, Son, Daughter, MGM, PGM, MGF, PGF)
DIABETES		
HYPERTENSION		
BREAST CANCER		
COLON CANCER		
OVARIAN CANCER		
THYROID DISORDER		

Have you had the BRCA genetic screening? ☐Yes ☐No. If yes, what year and result? _____

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

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

CANCELLATION, NO-SHOW POLICY & FINANCIAL

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: _____

Ambry Genetics®
A Konica Minolta Company

Women's Group of Gwinnett

PATIENT NAME	
DATE OF BIRTH	**TODAY'S DATE**

Hereditary Cancer Questionnaire

(to be completed by patients)

Instructions: This is a screening tool to help your healthcare provider determine if you would benefit from hereditary cancer genetic testing. Your healthcare provider will review this form looking for any risk factors for a hereditary cancer syndrome such as similar types of cancer running in the family, cancers diagnosed at young ages, or multiple cancer diagnoses in the same person.

DOES CANCER RUN IN YOUR FAMILY? Check those that apply.

Please fill this form out to the best of your ability. Please only consider family members related to you **by blood**, such as your parents, grandparents, children, brothers, sisters, aunts, uncles, and cousins. If you share only one parent with a brother or sister, **please indicate that.**

TYPE OF CANCER/ TUMORS	YOURSELF/PARENTS/ BROTHERS/SISTERS/ CHILDREN	AGE AT DIAGNOSIS (Estimates are OK)	EXTENDED FAMILY Aunts/Uncles/ Cousins/Grandparents	AGE AT DIAGNOSIS (Estimates are OK)	LIVING OR DECEASED (L OR D)
☑ EXAMPLE: Colorectal Cancer	Me	42	Aunt (mother's side Uncle (father's side)	46 55	L D
☐ BREAST CANCER (in women or men)					
☐ OVARIAN CANCER (peritoneal/Fallopian tube)					
☐ UTERINE CANCER					
☐ COLORECTAL CANCER					
☐ PANCREATIC CANCER					
☐ PROSTATE CANCER					
☐ KIDNEY CANCER					
☐ MELANOMA					
☐ BRAIN TUMOR Type: _____					
☐ OTHER CANCER Type: _____					
☐ MORE THAN 10 COLORECTAL POLYPS (indicate how many)					

☐ No personal or family history of cancer

☐ My family's heritage is Ashkenazi Jewish (an ethnic background that may have a higher likelihood of hereditary cancer)

☐ I, or someone in my family, have had genetic testing for a hereditary cancer syndrome.
(Please describe and provide a copy of test result if possible)

_____

_____

HEREDITARY BREAST AND OVARIAN CANCER SYNDROME

- 1 breast cancer diagnosed **before age 50**
- 2 breast cancers on the same side of the family, one **at age 50** or earlier (can be in the same person)
- 3 or more breast cancers on the same side of the family in 1st, 2nd, or 3rd degree relatives, **regardless of age** (one must be a 1st or 2nd degree relative
- 1 ovarian cancer **at any age**
- 1 male breast cancer **at any age**
- Bilateral breast cancer
- Triple negative breast cancer at or before age 60
- Ashkenazi Jewish patient and one breast, ovarian, or pancreatic cancer, regardless of age

LYNCH SYNDROME

- The patient has had endometrial cancer, **regardless of age**
- 1 endometrial/uterine cancer diagnosed **before age 50**
- 1 colon cancer diagnosed **before age 50**
- 3 or more colon, endometrial, ovarian, pancreatic, brain, small bowel, renal/pelvic cancers on the same side of the family

First Degree - parents, children, sisters, brothers

Second Degree - aunts, uncles, grandparents, nieces/nephews

FOR OFFICE USE

Patient offered genetic testing:

☐ Accepted ☐ Declined ☐ Undecided ☐ Not Applicable

☐ Follow-up appointment scheduled: _____

Healthcare Provider Signature: _____

One Enterprise, Aliso Viejo, CA 92656 USA Toll Free +1.866.262.7943 Fax +1.949.900.5501 ambrygen.com