



**PATIENT REGISTRATION & HEALTH QUESTIONNAIRE – PLEASE PRINT**

\*THIS FORM IS TO BE COMPLETED ANNUALLY\*

NAME: \_\_\_\_\_ PREFERRED NAME: \_\_\_\_\_

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

EMAIL: \_\_\_\_\_ REFERRED 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

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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.

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Please sign one of the below:

I understand and agree with the above transfusion policy.

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Signature

Date

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

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Signature

Date

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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 <ul style="list-style-type: none"> <li>• Preeclampsia</li> <li>• Gestational Diabetes</li> <li>• Premature Labor</li> <li>• Other/Specify</li> </ul>	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? \_\_\_\_\_  Cone Biopsy, year? \_\_\_\_\_
  - Cryotherapy, 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

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> CHLAMYDIA      | <input type="checkbox"/> HERPES-Type 2     | <input type="checkbox"/> PELVIC INFLAMMATORY DISEASE | <input type="checkbox"/> PCOS                      |
| <input type="checkbox"/> GONORRHEA      | <input type="checkbox"/> HERPES-Type 1     | <input type="checkbox"/> ENDOMETRIOSIS               | <input type="checkbox"/> FIBROCYSTIC BREAST TISSUE |
| <input type="checkbox"/> HIV            | <input type="checkbox"/> HEPATITIS B or C  | <input type="checkbox"/> FIBROIDS                    | <input type="checkbox"/> BREAST ABSCESS            |
| <input type="checkbox"/> SYPHILIS       | <input type="checkbox"/> BICORNUATE UTERUS | <input type="checkbox"/> POST MENOPAUSAL BLEEDING    | <input type="checkbox"/> VAGINAL PROLAPSE          |
| <input type="checkbox"/> HPV            | <input type="checkbox"/> DIDELPHIC UTERUS  | <input type="checkbox"/> INFERTILITY                 | <input type="checkbox"/> VAGINITIS/BV/YEAST        |
| <input type="checkbox"/> VENEREAL WARTS | <input type="checkbox"/> PMS/PMDD          | <input type="checkbox"/> 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
<input type="checkbox"/> D&C		<input type="checkbox"/> Endometrial biopsy	
<input type="checkbox"/> Hysteroscopy		<input type="checkbox"/> Left ovarian cyst(s) removed	
<input type="checkbox"/> Infertility Surgery		<input type="checkbox"/> Right ovarian cyst(s) removed	
<input type="checkbox"/> Tubal Ligation		<input type="checkbox"/> L ovary removed	
<input type="checkbox"/> Laparoscopy		<input type="checkbox"/> R ovary removed	
<input type="checkbox"/> Hysterectomy (Vaginal)		<input type="checkbox"/> Vaginal or bladder repair for prolapse or incontinence	
<input type="checkbox"/> Hysterectomy (Abdominal)		<input type="checkbox"/> Cesarean section	
<input type="checkbox"/> Myomectomy		<input type="checkbox"/> 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**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> HIGH BLOOD PRESSURE             | <input type="checkbox"/> ARTHRITIS                              | <input type="checkbox"/> THYROID DISEASE          |
| <input type="checkbox"/> HIGH CHOLESTEROL                | <input type="checkbox"/> ASTHMA, yr of last known attack? _____ | <input type="checkbox"/> HYPOTHYROIDISM           |
| <input type="checkbox"/> BREAST CANCER                   | <input type="checkbox"/> ANXIETY                                | <input type="checkbox"/> HYPERTHYROIDISM          |
| <input type="checkbox"/> DIABETES                        | <input type="checkbox"/> BIPOLAR, Type 1 or Type 2? _____       | <input type="checkbox"/> HEPATITIS, LIVER DISEASE |
| <input type="checkbox"/> DIET CONTROLLED                 | <input type="checkbox"/> DEPRESSION                             | <input type="checkbox"/> GERD/ACID REFLUX         |
| <input type="checkbox"/> Rx CONTROLLED                   | <input type="checkbox"/> MIGRAINES                              | <input type="checkbox"/> SKIN CONDITION: _____    |
| <input type="checkbox"/> INSULIN CONTROLLED              | <input type="checkbox"/> HEMORRHOIDS                            | <input type="checkbox"/> CANCER (SPECIFY) _____   |
| <input type="checkbox"/> GESTATIONAL                     | <input type="checkbox"/> HIV+                                   | _____   |
| <input type="checkbox"/> HEMATURIA                       | <input type="checkbox"/> BLOOD TRANSFUSION                      | <input type="checkbox"/> OTHER (SPECIFY) _____    |
| <input type="checkbox"/> HEART CONDITION (SPECIFY) _____ | <input type="checkbox"/> BLOOD CLOTS (LEG/THIGH/PULMONARY)      | _____   |
| _____  | <input type="checkbox"/> KIDNEY DISEASE                         | _____   |

**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.

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PATIENT AND/OR INSURED

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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.

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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 \_\_\_\_\_

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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.**

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Print Patient Name

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Patient Signature

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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: \_\_\_\_\_



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)
<input checked="" type="checkbox"/> EXAMPLE: Colorectal Cancer	Me	42	Aunt (mother's side Uncle (father's side)	46 55	L D
<input type="checkbox"/> BREAST CANCER (in women or men)					
<input type="checkbox"/> OVARIAN CANCER (peritoneal/Fallopian tube)					
<input type="checkbox"/> UTERINE CANCER					
<input type="checkbox"/> COLORECTAL CANCER					
<input type="checkbox"/> PANCREATIC CANCER					
<input type="checkbox"/> PROSTATE CANCER					
<input type="checkbox"/> KIDNEY CANCER					
<input type="checkbox"/> MELANOMA					
<input type="checkbox"/> BRAIN TUMOR Type: _____					
<input type="checkbox"/> OTHER CANCER Type: _____					
<input type="checkbox"/> MORE THAN 10 COLORECTAL POLYPS (indicate how many)					
<input type="checkbox"/> No personal or family history of cancer					
<input type="checkbox"/> My family's heritage is Ashkenazi Jewish (an ethnic background that may have a higher likelihood of hereditary cancer)					
<input type="checkbox"/> 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 1<sup>st</sup>, 2<sup>nd</sup>, or 3<sup>rd</sup> degree relatives, **regardless of age** (one must be a 1st or 2<sup>nd</sup> 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: \_\_\_\_\_