PATIENT DEMOGRAPHICS

Please complete this form in order to ensure proper billing of your services.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Today's Date: _____

Preferred Name: _____ Date of Birth: _____

Address (Street): _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Preferred Phone: ☐ Home ☐ Cell

Email Address: _____ Social Security: _____

PCP: _____ Ref. Physician (if different): _____

Sex: ☐ Male ☐ Female

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

Race: Which category best describes your racial background?

☐ American Indian ☐ Black or African American ☐ White ☐ Hispanic or Latino
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Unreported/Refused to Report

Ethnicity: How would you describe your ethnicity, such as your family background or ancestry?

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unreported/Refused to Report

Preferred language:

☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____

How did you hear about our practice? ☐ Health Plan ☐ Internet/Web Site ☐ Patient ☐ Other _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____ Work Phone: _____

EMERGENCY CONTACT

Contact: _____ Relationship to you: _____

Home Phone: _____ Alt.Phone: _____

INSURANCE INFORMATION

PRIMARY CARRIER: _____ Phone: _____

PRIMARY SUBSCRIBER NAME: _____ Date of Birth: _____ Relationship: _____

ID/Cert.#: _____ Group/Plan #: _____ Effective Date: _____

SECONDARY CARRIER: _____ Phone: _____

ID/Cert.#: _____ Group/Plan #: _____ Effective Date: _____

PHARMACY INFORMATION

Pharmacy Name: _____ ☐ Local ☐ Mail away

Address: _____ City: _____ State: _____ Zip: _____

☐ Initial

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 medications 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.

Any call 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.

OFFICE POLICIES AND AUTHORIZATIONS

ELECTRONIC COMMUNICATIONS

Initial ☐

Portal: We offer secure electronic communications between you and our office via our Patient Portral.
☐ Yes, I want to participate, use my email provided on my Patient Information Sheet
☐ No, I do not wish to participate at this time.

Automated Calls: We offer automated appointment reminders via a text message or an automated call for those who want to participate. ☐ Text ☐ Call ☐ Both
☐ Yes, I want to participate. Cell Phone # _____ ☐ No, I do not wish to participate at this time.

Voicemail Messages: ☐ Yes, you may leave medical information (such as test results) on my voicemail.
Cell Phone # _____ Home Phone # _____
Authorized to leave voicemail messages: ☐Home ☐Cell Authorized to call: ☐Home ☐Cell
☐ No, you may NOT leave medical information on my voicemail.

RELEASE OF MEDICAL HISTORY AND TREATMENT INFORMATION

Initial ☐

I authorize the following individual(s) to receive information pertaining to any financial, medical history and treatment received:

Name: _____ Relationship: _____ DOB: _____ Ph: _____

Name: _____ Relationship: _____ DOB: _____ Ph: _____

PATIENT ACKNOWLEDGEMENT/HIPAA

Initial ☐

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review this Notice of our Privacy Practices:

PATIENT AUTHORIZATIONS

Initial ☐

- I give permission to The Women's Group of Gwinnett to provide medical services for diagnosis and treatment.
- I hereby authorize the practice, The Women's Group of Gwinnett, to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- I hereby authorize assignment of financial benefits directly to the practice, The Women's Group of Gwinnett. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

PATIENT FINANCIAL RESPONSIBILITIES

Initial ☐

- I (or patient's guardian, if minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing my contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include but are not limited to:
  - Charge for returned checks $90
  - Charge for forms completion $25
  - Cost of collection services
  - Charge for copying and distribution of patient medical records.
  - Charge for missed appointments $25

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsiblity Form:

Signature of Patient or Guardian _____ Date: _____

INITIAL HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Date of Birth: _____

Main reason for today's visit? _____

ACCEPTANCE OF BLOOD PRODUCTS

In the case of a life-threatening emergency, it is our policy to transfuse with blood if it is necessary to save your life.
☐ I understand and agree with the above transfusion policy.
☐ I understand that if I am pregnant or needing surgery, I will not be able to keep my appointment if I decline.

Signature: _____ Date: _____

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 • Pre-eclampsia • 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? _____ ☐ 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 ☐Normal Bone Density
- Have you had a Colonoscopy? ☐Yes ☐No If yes, what year(s)? _____ Was it normal? ☐Yes ☐No
- When is the next Colonoscopy due? ☐1yr ☐3yrs ☐5yrs ☐10yrs ☐Other: _____

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

☐BREAST MASS
☐BENIGN ☐CANCER
☐CHLAMYDIA
☐ENDOMETRIOSIS
☐FIBROCYSTIC BREAST TISSUE
☐FIBROIDS
☐GONORRHEA
☐HEPATITIS B or C
☐HERPES-Type 1
☐HERPES-Type 2
☐HIV
☐HPV
☐INFERTILITY
☐PCOS
☐PELVIC INFLAMMATORY DISEASE
☐PMS/PMDD
☐POST MENOPAUSAL BLEEDING
☐SYPHILIS
☐TRICHOMONIASIS
☐UTERUS - BICORNUATE
☐UTERUS - SEPTUM
☐VAGINAL PROLAPSE
☐VAGINITIS/BV/YEAST
☐WARTS (GENITAL)
☐OTHER (SPECIFY) _____
_____

OTHER PAST GYNECOLOGICAL HISTORY: CONTINUED

- HAVE YOU RECEIVED THE GARDASIL VACCINE? (Series of 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
☐Cesarean section		☐Myomectomy	
☐D&C		☐Left ovarian cyst(s) removed	
☐Endometrial biopsy		☐Right ovarian cyst(s) removed	
☐Hysterectomy (Abdominal)		☐Left ovary removed	
☐Hysterectomy (Vaginal)		☐Right ovary removed	
☐Hysteroscopy		☐Tubal Ligation	
☐Infertility Surgery		☐Vaginal or bladder repair for prolapse or incontinence	
☐Laparoscopy		☐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

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

CURRENT MEDICATIONS (include dose/strength): _____

_____

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? _____

Recreational Drug Use (Marijuana, etc.): ☐Yes ☐Former ☐Never

Exercise: ☐Yes, how many 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 with estimated age at diagnosis Father, Mother, Brother, Sister, Son, Daughter, MGM, PGM, MGF, PGF)
BREAST CANCER		
COLON CANCER		
DIABETES		
HYPERTENSION		
OVARIAN CANCER		
THYROID DISORDER		

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