MEDICAL QUESTIONNAIRE

☐ Annual ☐ GYN/OB

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

Name: _____ Date of Birth: _____

Please list one main reason for visit 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 a Dexa scan 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?_____
- Recreational Drug Use (Marijuana, etc.): ☐Yes ☐Former ☐Never
- Exercise: ☐Yes, how days per week?_____ ☐Sedentary ☐Active, but no formal exercise
- Do you desire STD screening with today's visit? ☐Yes ☐No
- Have you had the Gardasil vaccine? ☐Yes ☐No. If yes, have you completed the series of all 3? ☐Yes ☐No
- In case of an emergency, I consent to a blood transfusion. ☐Yes ☐No.

Signature: _____ Date: _____

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: _____