GEORGIA
CENTER FOR WOMEN

PATIENT DEMOGRAPHIC FORM

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

PATIENT INFORMATION/INFORMATION

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

Other Name: _____ Date of Birth: _____

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

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

Address (street): _____ Address (street): _____

City, State, Zip: _____ City: _____ State: _____ Zip: _____

Telephone #: _____ Telephone #: _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑ Partner

EMPLOYMENT INFORMATION

Employer: _____

Employer Address (street): _____ City: _____ State: _____ Zip: _____

Emp. Status: ❑ Full Time ❑ Part Time ❑ Not Employed ❑ Self-Employed ❑ Active Military

Student Status: ❑ Full Time ❑ Part Time

INSURANCE INFORMATION

PRIMARY CARRIER: _____ Telephone #: _____

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

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

SECONDARY CARRIER: _____ Telephone #: _____

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

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

PARENT/GUARDIAN INFORMATION

Contact: _____ Relationship to You: _____

Home Phone: _____ Alt. Phone: _____

Contact: _____ Relationship to You: _____

Home Phone: _____ Alt. Phone: _____

ELECTRONIC COMMUNICATIONS

Portal: We offer secure electronic communications between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

☐ Yes, I want to participate, use my email provided on my HIPAA form

☐ No, I do not wish to participate at this time.

SIGNATURE OF PATIENT OR REPRESENTATIVE _____ DATE _____

ELECTRONIC COMMUNICATIONS *(CONTINUED)*

Automated Calls: As an added convenience, we offer automated appointment reminders via a text message or an automated call for those who want to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for appointment reminders.

I understand under the telephone consumer protection act, that in order for you to contact me by automated means for services relating to my medical care, including monies I may owe, etc., I agree that Georgia Center for Women and/or your agents may contact me by my cell phone, which may result in charges to me. You may also contact me by text messages, or emails providing that I have consented above. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automated dialing device, as applicable.

☐ Yes, I want to participate, my cell number is provided below.

Cell Phone Number: _____

☐ No, I do not wish to participate at this time.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

ADDITIONAL INFORMATION

Race: Which category best describes your racial background?

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ 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: What language do you usually speak at home?

☐ English ☐ Spanish ☐ Other _____

How did you hear about our practice? ☐ Health Plan ☐ Internet ☐ Our Web Site ☐ ER/Hospital ☐ Newspaper/Magazine ☐ Patient _____ ☐ Other _____

PHARMACY INFORMATION

Pharmacy Name: _____ ☐ **Local** ☐ **Mail away**

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

Phone: _____ **Fax:** _____

Pharmacy Name: _____ ☐ **Local** ☐ **Mail away**

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

Phone: _____ **Fax:** _____

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

GEORGIA
CENTER FOR WOMEN

HIPAA ACKNOWLEDGEMENTS AND AUTHORIZATIONS

I. HIPAA NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

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 acknowledgment that you have been given the option of receiving a copy or been afforded an opportunity to review this Notice of our Privacy Practices:

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

II. AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT CONTACT INFORMATION

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

I authorize Brief messages with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐ Work

I authorize Extended message details with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐ Work

I authorize secure electronic communications be sent to my email address at: _____

Restrictions/Instructions: _____

RELEASE OF MEDICAL HISTORY AND TREATMENT INFORMATION

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

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

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

Restrictions/Instructions: _____

RELEASE OF BILLING INFORMATION

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

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

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

Restrictions/Instructions: _____

PATIENT ACKNOWLEDGEMENT

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to your office address. My revocation will be effective once received by the practice, Georgia Center for Women.
2. A copy of this authorization may be used with the same effectiveness as the original. This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name: _____ Date: _____

Signature: _____ Relationship: _____

ADDITIONAL AUTHORIZATIONS

Emergency Contact: _____ Relationship: _____ Phone: _____

I request a female escort to be present during my examination? ☐ Yes ☐ No ☐ Other _____

GEORGIA
CENTER FOR WOMEN

AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS PATIENT FINANCIAL RESPONSIBILITY FORM

Patient's Name: _____ DOB: _____

Thank you for choosing our practice, Georgia Center for Women, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality of healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS

I give permission to the practice, Georgia Center for Women, to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice, Georgia Center for Women.

PATIENT FINANCIAL RESPONSIBILITIES

- 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 your 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.
  - Charge for the copying and distribution of patient medical records.
  - Charge for forms completion.
  - Charge for missed appointments.

PATIENT AUTHORIZATIONS

- By my signature below, I hereby authorize the practice, Georgia Center for Women, to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, Georgia Center for Women. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

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

Signature of Patient or Guardian _____ Date _____

GEORGIA
CENTER FOR WOMEN

PATIENT MEDICAL HISTORY

Patient Name: _____ DOB: _____

Please list any present medications: _____

MEDICAL HISTORY

Please check all that apply:

❑ Anxiety	❑ Asthma	❑ Depression	❑ Melanoma	❑ Epilepsy
❑ Fibroids	❑ Stroke	❑ Heart Murmur	❑ Colonic Polyps	❑ Kidney Stones
❑ Cancer, Breast	❑ Cancer, Colon		❑ Cancer, Rectal	❑ Cancer, Ovarian
❑ Cancer, Uterus	❑ Cancer, Endometrial		❑ Cancer, Cervical	

ALLERGIES

Please list any drug allergies: _____

GYN HISTORY

Last Pap Smear (mm/yyyy): _____

Result of last pap: ❑ Normal ❑ Abnormal ❑ No pap ever done

Self Breast Exam: ❑ Monthly ❑ Do not perform ❑ Sometimes

Have you had a Gardisil HPV Vaccine: ❑ Yes ❑ No

Last Mammogram Date (mm/yyyy): _____

Result of last Mammogram: ❑ Normal ❑ Abnormal ❑ No mammo ever done

Last Dexa (Bone Density) Scan (mm/yyyy): _____

Result of last Dexa Scan: ❑ Normal ❑ Osteopenia ❑ Osteoporosis

Last Colonoscopy (mm/yyyy): _____

Menstruation:

Age of Onset: At what age did your periods start? _____

LMP: Date of last menstrual period (dd/mm/yyyy)? _____

(If menopausal, skip to Menopause section now)

Time Between Periods: ❑ Irregular ❑ 21-32 Days apart ❑ > 45 Days apart ❑ < 21 Days apart ❑ 33 – 44 Days

Duration: How long does your period last? ❑ > 7 Days ❑ 2 – 7 Days ❑ 1 Day

Pad / Tampon Use Per Day? ❑ 1 – 3 ❑ 4 – 6 ❑ 7+

Associated Signs / Symptoms: How would you describe your period

❑ with severe pain ❑ with moderate pain

❑ with mild discomfort ❑ without discomfort / pain

❑ heavy ❑ light

Menstruation Symptoms:

Premenstrual Syndrome: ❑ Yes ❑ No

If **Yes**, please mark any symptoms you are experiencing:

❑ Withdrawal ❑ Weight gain ❑ Tension ❑ Pelvic Pain
❑ Mood Swings ❑ Tiredness ❑ Headaches ❑ Depression
❑ Bowel Changes ❑ Bloating ❑ Anxiety ❑ Changes in Desire
❑ Breast Swelling / Discomfort

Menopause: ❑ Yes ❑ No

If **Yes**, began at age: _____

Current menopausal symptoms:

❑ None ❑ Headache
❑ Hot Flashes ❑ Irritability
❑ Memory Loss ❑ Loss of Sexual Desire
❑ Weight Gain ❑ Vaginal Dryness

Birth Control:

❑ Condoms
❑ Oral Contraceptive Pills Indicate which pill: _____
❑ Mirena IUD ❑ Paraguard IUD
❑ Skyla IUD ❑ Diaphragm
❑ Nuvaring ❑ Bilateral Tubal Ligation
❑ Vasectomy ❑ None
❑ Depo-Provera ❑ Ortho Evra Patch
❑ Spermicide ❑ Nexplanon

If using an IUD or Nexplanon, please list the date of insertion (mm/yyyy): _____

Sexual Activity:

❑ Currently sexually active ❑ Not currently sexually active
Total Number of Sex Partners: _____
❑ Past history of sexual abuse: _____

_____

Currently or in the past, I have had sex: ❑ With Men ❑ With Women ❑ With both Men and Women

Sexually Transmitted Infections (STI's)?

❑ None
❑ Human Papilloma Virus (HPV) ❑ Herpes Simplex Virus (HSV)
❑ Chlamydia ❑ Gonorrhea
❑ Human Immunodeficiency Virus (HIV) ❑ Trichomoniasis (Trich)
❑ Hepatitis B ❑ Hepatitis C ❑ Syphilis

OB HISTORY

Total pregnancies: _____ Total living children: _____

Total full term pregnancies: _____ Total pre term pregnancies: _____

Total miscarriages / abortions: _____

Total Ectopic pregnancies: _____

Please fill out the following to the best of your recollection regarding your prior pregnancies

BIRTH DATE	# WEEKS PREGNANT AT BIRTH	HOURS IN LABOR	BIRTH WEIGHT	ANESTHESIA	DELIVERY METHOD	DELIVERY LOCATION AND PROVIDER
					❑ Vaginal ❑ C-Section	
Comments or Complications (i.e. diabetes, blood pressure, etc.)						
					❑ Vaginal ❑ C-Section	
Comments or Complications (i.e. diabetes, blood pressure, etc.)						
					❑ Vaginal ❑ C-Section	
Comments or Complications (i.e. diabetes, blood pressure, etc.)						

SURGICAL HISTORY

Please list any previous surgeries and c-sections (include minor surgeries like wisdom teeth, appendix, etc.). Please indicate approximate date:

_____

_____

_____

_____

_____

Have you ever had a blood transfusion? ❑ Yes ❑ No

HOSPITALIZATIONS

Please list any hospitalizations:

_____

_____

_____

_____

_____

FAMILY HISTORY

Please check all that apply for the corresponding family member. Under status, please indicate "alive", "deceased", or "unknown". Please put an "X" in the appropriate boxes below:

	STATUS	YEAR OF BIRTH	AGE	HEART DISEASE	BREAST CANCER	OVARIAN CANCER	COLON CANCER	BLEEDING DISORDER	BLOOD CLOTTING DISORDER
Mother									
Father									
Sister #1									
Sister #2									
Brother #1									
Brother #2									
Son #1									
Son #2									
Daughter #1									
Daughter #2									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									
Maternal Aunt									
Maternal Uncle									
Paternal Aunt									
Paternal Uncle									
Cousin									

SOCIAL HISTORY

SMOKING:

Current smoking status:

❑ Current smoker ❑ Former smoker

❑ Nonsmoker ❑ Current every day smoker ❑ Current some day smoker

❑ Smoker, status unknown ❑ Unknown if ever smoker

If you currently smoke, how often do you smoke cigarettes?

❑ Every day ❑ Some days, but not every day

If you currently smoke, how many cigarettes a day do you smoke?
❑ 5 or less ❑ 6 – 10 ❑ 11 – 20 ❑ 21 – 30 ❑ 31 or more
If you currently smoke, how soon after waking do you smoke your first cigarette?
❑ within 5 minutes ❑ 6-30 minutes ❑ 31-60 minutes ❑ after 60 minutes
Are you interested in quitting?
❑ Ready to quit ❑ Thinking about quitting ❑ Not ready to quit

ALCOHOL:
Did you have a drink containing alcohol in the past year? ❑ Yes ❑ No
How often did you have a drink containing alcohol in the past year?
❑ Never ❑ Monthly or less ❑ 2 – 4 times a month
❑ 2 – 3 times a week ❑ 4 or more times a week
How many drinks did you have on a typical day when you were drinking in the past year?
❑ 1 – 2 drinks ❑ 3 – 4 drinks ❑ 5 – 6 drinks ❑ 7 – 9 drinks ❑ 10 or more drinks
How often did you have 6 or more drinks on one occasion in the past year?
❑ Never ❑ Less than monthly ❑ Monthly ❑ Weekly ❑ Daily or almost daily

DRUGS:
Have you used drugs other than those for medical reasons in the past year? ❑ Yes ❑ No

CAFFEINE INTAKE: ❑ None ❑ 1 – 2 cups per day ❑ 2 – 3 cups per day
❑ 3 – 4 cups per day ❑ More than 4 cups per day

ANY HISTORY OF DOMESTIC VIOLENCE?
❑ None ❑ History in the past ❑ Has restraining order
❑ Feel unsafe at home ❑ Have a safety plan
Has your current partner ever threatened you or made you feel afraid? ❑ Yes ❑ No
Does your current partner or someone important to you hurt you physically or emotionally? ❑ Yes ❑ No

EXERCISE FREQUENCY: ❑ Never ❑ Occasionally ❑ 1 – 2 times per week
❑ 2 – 3 times per week ❑ 3 – 4 times per week ❑ 4 – 7 times per week

ANY HISTORY OF VERBAL ABUSE: ❑ None ❑ Occasional ❑ Frequent
❑ Seeking counseling ❑ Has safety plan

IF YOU ARE CURRENTLY PREGNANT, PLEASE ANSWER THE QUESTIONS BELOW:
Date of first positive pregnancy test (mm/dd/yyyy): _____
List any medications you have taken during this pregnancy: _____
_____
Were you on the pill or using contraception when you became pregnant? ❑ Yes ❑ No
Name of baby's father: _____
Name of partner: _____
How much alcohol, including beer, have you drank during this pregnancy?
(if none, write none) _____
Do you have a cat? ❑ Yes ❑ No
What is the baby's father's family / ethnic background? _____
Have you or the baby's father ever been tested for Tay-Sachs, Canavan, or Gaucher's Disease? ❑ Yes ❑ No

POS Reorder # 2002944