



2905 Jordan Ct, Suite G, Alpharetta, GA 30004 P: (678)335-9223 F: (678)335-9236

Patient Information

Date _____

Last Name _____ First _____ Middle _____

Preferred Name _____ Maiden Name _____

Social Security # _____ Date of Birth _____

Race _____ Religion _____ Language _____ Marital Status: Single Married Divorced
 Widowed

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Office Phone _____

Email Address _____ Contact Preference _____

Employer _____

Spouse's Last Name _____ First _____ Middle _____

Spouse's Date of Birth _____ Spouse's Cell Phone _____

Pharmacy Name _____ Phone _____

Pharmacy Address _____ City _____ Zip _____

Primary Care Physician/ Practice Name _____ Phone _____

Primary Care Physician's Address _____ City _____ Zip _____

How did you hear about our Practice? _____

Authorization to Treat Minor:

Last Name _____ First _____ DOB _____

Parent Guardian Other _____

Phone _____

Signature _____ Date _____

Insurance Information

Primary Insurance _____

Policy # _____ Group # _____

Policy Holder Name _____ Relationship to You Self Spouse
Parent

Policy Holder Birthdate _____ Policy Holder Social Security # _____

Secondary Insurance _____

Policy # _____ Group # _____

Policy Holder Name _____ Relationship to You Self Spouse
Parent

Please give your insurance cards to the receptionist so we may keep a copy on file

I authorize Alpha OB GYN to furnish all information required to insurance carriers and other health care providers regarding my illness and treatment. I assign to Alpha OB GYN all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. This information includes Protected Health Information.



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Signature _____ Date _____

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to you and your healthcare needs. Please understand that payment of your bills is considered part of your care. The following is a statement of our financial policy. We require that all our patients read and sign it prior to treatment or consultation.

All patients must complete required information and provide insurance information before seeing the doctor/provider.

PAYMENT IN FULL IS DUE (UPON REQUEST) AT THE TIME OF SERVICE

For your convenience, we accept Cash, Credit Card or Debit Cards.

Please initial after each number.

1. ____ It is the responsibility of the patient to confirm that the physician/provider is participating with the insurance plan and that your benefits are active. Our office will file claims to your insurance company for professional services rendered. We cannot bill your insurance carrier unless you give us your current insurance information. Please remember, **INSURANCE COVERAGE IS A LEGAL CONTRACT BETWEEN THE PATIENT AND THE INSURANCE COMPANY.** Benefits may differ depending upon what type of contract you have with the carrier. If your insurance company has not paid your account in full at the end of 60 days, the balance will automatically be transferred to your responsibility for payment in full.
2. ____ All **co-pays and payment dues will be collected at the time of treatment.** We require payment in full for your portion at the time of service. In office, we accept Visa, MasterCard, Discover, American Express and cash. Ultimately, you are responsible for all charges incurred in our office. The insurance contractual obligation does not allow us to write off co-pays or deductible amounts.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPONSIBILITY AS DESCRIBED ABOVE.

Print Patient Name/ Date of birth

X _____
Signature of Patient or Responsible Party



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Witness

Date

Communication Consent

In compliance with federal law, it is the policy of Alpha OB GYN to NOT release confidential, personal, and/or unauthorized information by home telephone, answering machine where the recorded message does not identify the name or number called. Information will not be left with an unauthorized person who may answer your telephone.

Please list authorized numbers:

I authorize Alpha OB GYN to leave medical information pertaining to my care by the following methods and will assume responsibility to notify Alpha OB GYN whenever this information changes.

Home Telephone _____

Cellular Telephone _____

E-Mail Address _____

I authorize Alpha OB GYN to leave medical information pertaining to my care to the following person/persons and will assume responsibility to notify Alpha OB GYN whenever this information changes.

Spouse/Significant Other _____

Other(Specify) _____

Please list authorized names and numbers:

PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received a copy of Alpha OB GYN's Notice of Privacy Practices.

X _____

Date: _____

Patient Signature/ Date of Birth

X _____

Date: _____

Guardian Signature (if patient is under 18)

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan in the past two years. This includes prescription medicines to treat HIV/AIDS and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.



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This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for you to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Patient Name _____ Signature _____



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Patient Information

Date _____

Last Name _____ First _____ Middle _____

Maiden Name _____ Date of Birth _____ Age _____ Marital Status _____

Reason for Today's Visit (Circle) Annual Exam Postoperative Visit Pregnancy Confirmation OB

Gynecologic Problem (explain) _____

Do you have any new medical concerns today? [] No [] Yes

Date of Last Pap _____ Are you currently Pregnant? _____

Have you ever had an abnormal pap? [] No [] Yes If Yes, when? _____

1st day of your Last Period _____ Was it normal? _____

Birth Control Method (circle) None Vasectomy Condom IUD Tubal Ligation/Essure Diaphragm

Birth Control Pill/Patch/Ring (name) _____ Other _____

Medications Please list all current medications and dosages as accurately as possible (including over-the-counter drugs)

Table with 3 columns: MEDICATION, DOSAGE, APPROX. DATE PRESCRIBED

Medication Allergies _____ None

Please list all medication allergies or check if none _____ Are you allergic to Latex?

PLEASE DO NOT WRITE BELOW THIS LINE

Para _____ BP _____ Weight _____ U/A _____ UCG _____

Pap _____ HR HPV _____ Wet Prep _____ KOH _____ Guaiac _____

Cultures/Other: Yeast Genprobes Urine Culture

Blood Tests: _____

Notes _____

Changes in Medical/Surgical History _____



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Name _____

Date _____

Medical History

Menstrual Cycle History

Age at 1st period _____ # of days between periods _____ Length of Period _____ days

Do you have: _____ Excessive Bleeding _____ Pain/Cramps _____ Mood Swings _____ Bleeding Between Periods

GYN History

If yes, please provide date and brief explanation

Have you ever had an abnormal pap smear? No Yes _____

Do you have problems with vaginal discharge? No Yes _____

Do you have any urinary problems or leakage? No Yes _____

Do you have any breast problems? No Yes _____

Have you had a MAMMOGRAM? No N/A Yes(date of most recent) _____

Have you had a BONE DENSITY SCAN? No N/A Yes(date of most recent) _____

Have you had a COLONOSCOPY? No N/A Yes(date of most recent) _____

Have you received the HPV Vaccine? No N/A Yes(date of most recent) _____

Please check if you have or have had any of the following:

Fibroids Ovarian Cysts Endometriosis Pelvic Adhesions/Pain
 Herpes Chlamydia/Gonorrhea Condyloma (warts) HPV
 HIV/AIDS PMS Other _____

Pregnancy History # of pregnancies _____ # of full term births _____ # of elective terminations _____
 # of living children _____ # of premature births _____ # of miscarriages _____

Date Born	Sex	Birth Weight	# weeks Pregnant	Hours in Labor	Type of Delivery	Pain Meds	Complications



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Personal Medical History (Please check all that apply)

- No known Problems Breast Problems Heart Disease Lupus/Autoimmune Disorder
- Alcohol/Drug Abuse Cancer (explain) Hepatitis Mitral Valve Prolapse
- Asthma _____ High Blood Pressure Physical Abuse
- Birth Defects _____ High Cholesterol Seizure Disorder
- Blood Clots Depression/Anxiety Hypothyroidism Stroke
- Blood Disorder/Anemia Diabetes Kidney/Bladder Problems Thyroid Problems
- Other Medical Problems (list) _____

Surgical Medical History

Month/Year	Type of Surgery	Complications(if yes, explain)

Family Medical History (please check all that apply)

- No Known Problems
- Has anyone in your immediate family had
- Alcohol/Drug Abuse Cancer(explain) Diabetes High Blood Pressure
- Birth Defects _____ Endometriosis High Cholesterol
- Blood Disorder/Anemia _____ Heart Disease Stroke
- Other Medical Problems (list) _____

Social History

- What is your occupation? _____
- Do you smoke? No Yes # packs per day _____ Former When did you quit? _____ How long did you smoke? _____
- Do you drink alcohol? No Yes _____ # per _____ (day/week/month)
- Do you exercise? No Yes Type _____ Hours per week _____
- Do you use street drugs? No Yes How often? _____
- Are you sexually active? No Yes Do you have one partner _____ or many partners _____?

I certify the preceding information is correct to the best of my knowledge.



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