2905 Jordan Ct, Suite G, Alpharetta, GA 30004 P: (678)335-9223 F: (678)3359236

## 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.

**Signature** _____ **Date** _____

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# 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.**

_____ X_____

Print Patient Name/ Date of birth | Signature of Patient or Responsible Party

_____ _____

Witness | Date

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## 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 _____

**Please list authorized names and numbers:**

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)_____

_____

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.

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)

| 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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| | | | | | | | |
| | | | | | | | |

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**Name**_____ **Date**_____

***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.***

Signature_____ Date _____