Prestige Healthcare Atlanta, LLC
Where Wellness is Our Focus

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OFFICE POLICIES

NEW PATIENT PAPERWORK
Please complete the new patient paperwork prior to arriving to your appointment. When you do not do this, it delays your appointment and other patients after you.

MISSED APPOINTMENTS
Our goal is to provide quality care to all of our patients. When an appointment is scheduled, a block of time in the doctors' schedule has been allotted to you, the patient, to allow adequate time to address all of your concerns and provide medical treatment. We reserve the right to charge a $25.00 fee for all missed appointments that have not been cancelled 24 hours prior to the scheduled appointment time.

LATE APPOINTMENTS
All patients that arrive more than 15 minutes late for a scheduled appointment may be rescheduled. This does not apply if prior arrangements have been made.

FINANCIAL RESPONSIBILITY
Your signature on this form acknowledges that you, the patient, agree to bear full financial responsibility for all services provided if:

1. You are determined not to be eligible for insurance coverage.
2. The services are not covered under your benefit plan.
3. The services have not been otherwise referred and/or authorized as required by your health plan.
4. You are seeking services "out of network" with a non-contracting provider.

RETURNED CHECKS
A fee of $35.00 for checks returned to us for insufficient funds will be charged to your account. Future services will require payment by cash, money order or credit card for your payment obligations.

I have read and understand the above stated office polices. By signing this form, I agree to comply with these policies.

Print Patient Name: _____
Patient or Legal Signature: _____ Date: _____

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PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	SS #:	DATE: / /
ADDRESS			
CITY:	STATE/ZIP:		
HOME TELEPHONE:	WORK TELEPHONE: ( )		
EMPLOYER:	INSURANCE:	POLICY NO.:	
NAME YOU WOULD LIKE US TO USE:	NAME OF SPOUSE/PARTNER:		
NAME OF INSURED:	BIRTH DATE: / /	SS #:	
EMERGENCY CONTACT:	RELATIONSHIP:		
	HOME TELEPHONE: ( )	WORK TELEPHONE: ( )	
PHARMACY LOCAL:	MAIL ORDER:		
WHY HAVE YOU COME TO THE OFFICE TODAY?	REFERRED BY:		
IF YOU ARE HERE FOR AN ANNUAL EXAMINATION IS THIS A ☐ PRIMARY CARE VISIT OR ☐ GYNECOLOGY ONLY			
IS THIS A NEW PROBLEM?			
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT HAS LASTED.			

GYNECOLOGIC HISTORY

	PHYSICIAN'S NOTES
AGE PERIODS BEGAN: _____ LAST MENSTRUAL PERIOD: _____	
DAYS BETWEEN PERIODS _____ LENGTH OF FLOW _____	
HAVE YOU EVER HAD SEX? _____ ARE YOU CURRENTLY SEXUALLY ACTIVE? _____	
NUMBER OF SEXUAL PARTNERS (LIFETIME): _____	
SEXUAL PARTNERS ARE ☐ MEN ☐ WOMEN ☐ BOTH	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST? _____ WHAT WAS THE RESULT? _____	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO BREAST SELF-EXAMINATIONS?	
HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE (GONORRHEA, CHLAMYDIA, ETC)?	
WHEN WAS YOUR LAST MAMMOGRAM? _____ HAS IT EVER BEEN ABNORMAL? _____	
WHEN WAS YOUR LAST DEXA OR BONE DENSITY TEST?	
WHEN WAS YOUR LAST COLONOSCOPY?	

PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	SS #:	DATE: / /

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	PHYSICIAN'S NOTES
1.						
2.						
3.						
4.						

ANY PREGNANCY COMPLICATIONS?

☐ DIABETES ☐ HYPERTENSION/HIGH BLOOD PRESSURE ☐ PREECLAMPSIA/TOXEMIA ☐ OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? ☐ NO ☐ YES, HOW TREATED

CURRENT MEDICATIONS
(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: ☐ LIVING ☐ DECEASED-CAUSE: AGE:	FATHER: ☐ LIVING ☐ DECEASED-CAUSE: AGE:
SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):	
NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):	

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET	PHYSICIAN'S NOTES
DIABETES	☐		
STROKE	☐		
HEART DISEASE	☐		
BLOOD CLOTS IN LUNGS OR LEGS	☐		
HIGH BLOOD PRESSURE	☐		
HIGH CHOLESTEROL	☐		
OSTEOPOROSIS (WEAK BONES)	☐		
HEPATITIS	☐		
HIV/AIDS	☐		
TUBERCULOSIS	☐		
BIRTH DEFECTS	☐		
ALCOHOL OR DRUG PROBLEMS	☐		
BREAST CANCER	☐		
COLON CANCER	☐		
OVARIAN CANCER	☐		
UTERINE CANCER	☐		
MENTAL ILLNESS/DEPRESSION	☐		
ALZHEIMER'S DISEASE	☐		
OTHER	☐		

PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	SS #:	DATE: / /

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	☐	☐	
ALCOHOL DRINKS PER DAY: DRINKS PER WEEK: TYPE OF DRINK:	☐	☐	
DRUG USE	☐	☐	
SEAT BELT USE	☐	☐	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	☐	☐	
DAIRY PRODUCT INTAKE AND/OR CALCIUM SUPPLEMENTS DAILY INTAKE:	☐	☐	
HEALTH HAZARDS AT HOME OR WORK?	☐	☐	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	☐	☐	
DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL?)	☐	☐	
ARE YOU AN ORGAN DONOR?	☐	☐	

PERSONAL PROFILE

SEXUAL ORIENTATION: ☐ HETEROSEXUAL ☐ HOMOSEXUAL ☐ BISEXUAL
MARITAL STATUS: ☐ MARRIED LIVING WITH PARTNER SINGLE WIDOWED DIVORCED
NUMBER OF LIVING CHILDREN:
NUMBER OF PEOPLE IN HOUSEHOLD:
SCHOOL COMPLETED: ☐ HIGH SCHOOL ☐ SOME COLLEGE/AA DEGREE ☐ COLLEGE ☐ GRADUATE DEGREE ☐ OTHER
CURRENT OR MOST RECENT JOB:
TRAVEL OUTSIDE THE UNITED STATES: LOCATION(S):

PERSONAL PAST HISTORY OF ILLNESSES/DISEASES

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

PATIENT NAME:	BIRTH DATE: / /	SS #:	DATE: / /

REVIEW OF SYSTEMS (ROS)

1. CONSTITUTIONAL	☐ NEGATIVE ☐ WEIGHT LOSS ☐ WEIGHT GAIN ☐ CHANGE IN WEIGHT ☐ FEVER ☐ FATIGUE ☐ OTHER TALLEST HEIGHT
2. EYES	☐ NEGATIVE ☐ VISION CHANGE ☐ GLASSES/CONTACTS ☐ OTHER
3. EAR, NOSE, AND THROAT	☐ NEGATIVE ☐ ULCERS ☐ SINUSES ☐ MOUTH SORES ☐ HEADACHE ☐ HEARING LOSS ☐ OTHER ☐ DENTAL PROBLEMS
4. CARDIOVASCULAR	☐ NEGATIVE ☐ CHEST PAIN ☐ DIFFICULTY BREATHING ON EXERTION ☐ SWELLING IN LEGS ☐ RAPID HEART BEAT
5. RESPIRATORY	☐ NEGATIVE ☐ WHEEZING ☐ COUGHING UP BLOOD ☐ SHORTNESS OF BREATH ☐ COUGH OTHER
6. GASTROINTESTINAL	☐ NEGATIVE ☐ DIARRHEA ☐ BLOODY STOOL ☐ INVOLUNTARY LOSS OF GAC/STOOL ☐ CONSTIPATION ☐ FLATULENCE ☐ PAIN ☐ NAUSEA/VOMITING/INDIGESTION ☐ OTHER
7. GENITOURINARY	☐ NEGATIVE ☐ BLOOD IN URINE ☐ PAINFUL URINATION ☐ URGENCY ☐ FREQUENCY ☐ INCOMPLETE EMPTYING ☐ INCONTINENCE ☐ PAINFUL INTERCOURSE ☐ ABNORMAL OR PAINFUL PERIODS ☐ PMS ☐ ABNORMAL VAGINAL BLEEDING ☐ ABNORMAL VAGINAL DISCHARGE ☐ OTHER
8. MUSCULOSKELETAL	☐ NEGATIVE ☐ MUSCLE WEAKNESS ☐ MUSCLE OR JOINT PAIN ☐ OTHER
9a. SKIN	☐ NEGATIVE ☐ RASH ☐ ULCERS ☐ SKIN CHANGES ☐ DRY SKIN ☐ MOLES ☐ OTHER
9b. BREAST	☐ NEGATIVE ☐ PAIN IN BREAST ☐ DISCHARGE ☐ LUMPS ☐ OTHER
10. NEUROLOGIC	☐ NEGATIVE ☐ PASSING OUT ☐ SEIZURES ☐ NUMBNESS ☐ TROUBLE WALKING ☐ SEVERE MEMORY PROBLEMS OTHER ☐
11. PSYCHIATRIC	☐ NEGATIVE ☐ DEPRESSION ☐ CRYING ☐ SEVERE ANXIETY ☐ OTHER
12. ENDOCRINE	☐ NEGATIVE ☐ DIABETES ☐ HYPOTHYROID ☐ HYPERTHYROID ☐ HOT FLASHES ☐ HAIR LOSS ☐ HEAT/COLD INTOLERANCE ☐ OTHER
13. HEMATOLOGIC/LYMPHATIC	☐ NEGATIVE ☐ BRUISES ☐ BLEEDING ☐ ENLARGED LYMPH NODES/GLANDS ☐ OTHER
14. ALLERGIC/IMMUNOLOGIC	MEDICATIONS (PLEASE LIST) ☐ LATEX ☐ OTHER

FORM COMPLETED By: ☐ PATIENT ☐ OFFICE NURSE ☐ PHYSICIAN ☐ OTHER:	
SIGNATURE OF PATIENT:	
DATE REVIEWED BY PHYSICIAN WITH PATIENT: / /	PHYSICIAN SIGNATURE:

PHYSICIAN'S NOTES:

ANNUAL REVIEW OF HISTORY

DATE REVIEWED: / /	PHYSICIAN SIGNATURE:
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