GWINNETT OB/GYN ASSOCIATES, P.C.

Today's Date: _____ Chart #: _____

PATIENT INFORMATION (please print – blue or black ink only)

Name: _____ Age: _____ Birth Date: _____
Last First MI

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

Home Phone: _____ Cell Phone: _____ E-Mail Address: _____
Text "Gwinnett" to 622622 for appointment reminders.

Social Security Number: _____ Primary Care Physician: _____

Employed? (circle one) Yes No **Full-time Student?** (circle one) Yes No

Employer: _____ Work Phone: _____ Occupation: _____

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

Marital Status (circle one) Single Married Divorced Widowed **Who referred you here?** _____

SPOUSE INFORMATION

Name: _____ Social Security Number: _____ Birth Date: _____

Employer: _____ Work Phone: _____ Cell Phone: _____

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

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____

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

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

INSURANCE INFORMATION

Primary Insurance Co. Name: _____ Group #: _____ ID# _____

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

Policy Holder's Name: _____ Social Security Number: _____

Date of Birth: _____ Relation to Patient (circle one) Self Spouse Mother Father Other

Secondary Insurance Co. Name: _____ Group #: _____ ID#: _____

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

Policy Holder's Name: _____ Social Security Number: _____

Date of Birth: _____ Relation to Patient (circle one) Self Spouse Mother Father Other

I authorize the release of any medical information necessary to process insurance claims. My signature also authorizes payment of medical benefits to the named provider for professional services rendered. I understand that I am financially responsible for all services rendered, that there is a $30 returned check fee and that 30% will be added to my balance if my account must be referred to an agency for collection. Additionally, I understand that if I am covered by an insurance that requires a referral number, it is my responsibility to obtain that referral number prior to my visit.

_____ _____
(Patient's Signature) (Date)

GWINNETT OB/GYN ASSOCIATES, P.C.
Gynecology Questionnaire

NAME:_____ **DATE:**_____

DATE OF BIRTH:_____

REASON FOR VISIT: (If not routine, briefly describe main symptoms.) _____

_____

PAST MEDICAL HISTORY:

List all operations you have had.

	OPERATION	DATE
A.		
B.		
C.		
D.		
E.		
F.		

List all illnesses you have had that required hospitalization.

	ILLNESS	DATE
A.		
B.		
C.		
D.		
E.		
F.		

Have you ever had? (Check yes or no and give dates.)

YES	NO	ILLNESS	DATE
( )	( )	Migraine Headaches	
( )	( )	Thyroid Disorder	
( )	( )	Pneumonia	
( )	( )	Tuberculosis	
( )	( )	Heart Murmur	
( )	( )	High Blood Pressure	
( )	( )	Rheumatic Fever	
( )	( )	Diabetes	
( )	( )	German Measles or Vaccine	
( )	( )	Anemia	
( )	( )	Convulsions or Seizures	
( )	( )	Ulcers	
( )	( )	I will accept blood products if necessary	

YES	NO	ILLNESS	DATE
( )	( )	Jaundice of Hepatitis	
( )	( )	Kidney Stones	
( )	( )	Kidney Infection	
( )	( )	Bladder Infection	
( )	( )	Genital Herpes	
( )	( )	Gonorrhea	
( )	( )	Syphilis	
( )	( )	Broken Bones	
( )	( )	Arthritis	
( )	( )	Mental Illness	
( )	( )	Serious Injury	
( )	( )	Blood Transfusion	

Please list any additional medical conditions or illnesses:

ILLNESS	DATE

REVIEW OF SYSTEMS:
Are you currently having or have you recently had any of these symptoms? (Check "**YES**" or "**NO**")

A. GENERAL

YES	NO	
( )	( )	Recent weight gain
( )	( )	Recent weight loss
( )	( )	Depression
( )	( )	Headaches
( )	( )	Eye pain
( )	( )	Spots in front of eyes
( )	( )	Double vision
( )	( )	Glasses
( )	( )	Deafness
( )	( )	Nose bleeds

B. CHEST AND HEART

YES	NO	
( )	( )	Palpitation
( )	( )	Skipped or irregular heart beats
( )	( )	Chest discomfort on exertion
( )	( )	Chest pain with breathing
( )	( )	Shortness of breath with exertion
( )	( )	Awakening at night short of breath
( )	( )	Shortness of breath lying down
( )	( )	Coughing up blood

C. BREASTS

YES	NO	
( )	( )	Breast lump
( )	( )	Breast tenderness
( )	( )	Nipple discharge
( )	( )	Family history of breast cancer
( )	( )	Previous mammogram date _____

D. GASTROINTESTINAL

YES	NO	
( )	( )	Change in bowel habits
( )	( )	Constipation
( )	( )	Diarrhea
( )	( )	Bright blood in stools
( )	( )	Clay colored stools
( )	( )	Black stools
( )	( )	Abdominal pain
( )	( )	Hemorrhoids
( )	( )	Vomiting up blood
( )	( )	Painful bowel movements
( )	( )	Nausea or vomiting

E. GENITO-URINARY

YES	NO	
( )	( )	Frequent or painful urination
( )	( )	Difficulty holding urine
( )	( )	Difficulty starting urine
( )	( )	Excessive urine
( )	( )	Frequent night urination
( )	( )	Change of color of urine
( )	( )	Blood or pus in urine
( )	( )	Wetting in bed

F. EXTREMITIES

YES	NO	
( )	( )	Varicose veins
( )	( )	Pain in legs when walking
( )	( )	Blood clots in legs
( )	( )	Skin rashes
( )	( )	New or growing moles

GWINNETT OB/GYN ASSOCIATES, P.C.

Gynecology Questionnaire (Sheet 2)

NAME: _____

MEDICATIONS: (List **ALL** medications that you take regularly or have taken recently, include all non-prescription drugs.)

1._____ 3._____

2._____ 4._____

ALLERGIES: Are you allergic to any medications, drugs, chemicals or food? (If **YES**, list which ones) _____

_____

_____

CONTRACEPTIVE HISTORY: (List present and previous history of birth control you have used.)

	METHOD TYPE	DURATION OF USE	COMPLICATIONS
PRESENT			
PREVIOUS			

OBSTETRIC HISTORY: (List all pregnancies, dates, and outcomes.)

	DATE	DURATION	SEX	WEIGHT	COMPLICATIONS
1.					
2.					
3.					
4.					
5.					
6.					

FAMILY HISTORY: (List family members (father, mother, sister, brother) with any current health problems and their ages. Also list deceased family members, the cause of death and their ages at death.) _____

_____

_____

Have any other blood relatives had serious medical problems or inherited problems? Any children born in the family with an abnormality?

_____

_____

_____

SOCIAL HISTORY:

Do you smoke cigarettes? ☐ Yes No ☐ How many/day? _____ How many years? _____

Do you drink alcohol? ☐ Yes No ☐ How many drinks/day? _____ Per week? _____

Do you get any regular exercise? ☐ Yes No ☐ How often? _____

GYNECOLOGIC HISTORY:

MENSTRUAL HISTORY

First day of last period: _____ Age first started period: _____ Usual number of days from one period to the next: _____

Usual # of days of flow: _____ Are your periods: Light ☐ Moderate ☐ Heavy Any excessive bleeding or spotting between cycles? ☐ Yes No ☐

Cramps with periods? ☐ Yes No ☐ Depression, anxiety, emotional upset before periods? ☐ Yes No ☐

PAP SMEARS:

Last pelvic exam: _____ Last pap smear: _____ Have you ever had an abnormal pap? ☐ Yes No ☐

If yes, what treatment was done? _____ Have your paps been normal since treatment? ☐ Yes No ☐

Did your mother take hormones while pregnant with you? ☐ Yes No ☐

VAGINITIS:

Yeast: _____ Trichomonas: _____ Non-specific/Bacterial Vaginitis: _____

Are you having any problem with discharge now? ☐ Yes No ☐

SEXUAL HISTORY:

Any problems with pain? ☐ Yes No ☐ Any problem with Orgasm? ☐ Yes No ☐ Other? _____

Any history of STDs? HPV ☐ Yes No ☐ Herpes ☐ Yes No ☐ Syphilis ☐ Yes No ☐ Hepatitis ☐ Yes No HIV ☐ Yes No ☐

Gonorrhea ☐ Yes No Chlamydia ☐ Yes No ☐ Other? _____

List any Gynecologic surgeries, dates and reasons for surgery: _____

_____

_____

_____

_____

_____

Gwinnett OB/GYN Associates, P.C.
1700 Tree Lane Road
Suite 290
Snellville, GA 30078

PATIENT'S CONFIDENTIALITY INSTRUCTIONS

Patient Name _____ **Acct#** _____

It is important for us to honor the confidentiality between patient and physician.
PLEASE CHECK YOUR PREFERENCE BELOW.

_____ **You may discuss my medical information ONLY with me.**

_____ **I give my permission to discuss my medical information with the following people:**

_____ **Relationship** _____

_____ **Relationship** _____

_____ **Relationship** _____

Yes or No (circle one) **You may leave medical information (test results) on my voice mail at:**

Cell #_____

Home # _____

Signed _____ **Date** _____

Acceptance of Blood Products

At Gwinnett OB/GYN we strive for optimum health and to preserve life.

In the case of a life threatening emergency, **it is our policy to transfuse with blood if it is necessary to save your life.**

Please sign one of below:

I understand and **agree** with the above transfusion policy.

_____

Print Name Signature Date

I **disagree** and will be transferring my care elsewhere.

_____

Signature Date

_____

Witness Signature Date 3/5/14

Patient Name: _____

Date of Birth: _____

We are now sending prescriptions electronically to patient pharmacies. In order for us to be able to do this we will need your pharmacy information. Please fill out the information below.

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Telephone Number: _____

Gwinnett OB-GYN Associates, P.C.

Gwinnett OB·GYN ASSOCIATES

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PRACTICE POLICIES AND GUIDELINES AGREEMENT

Welcome! We are so glad that you have decided to become a part of our practice. Our goal is to provide you with excellent healthcare in a friendly and compassionate environment. Please take a moment to become familiar with our office's policies and guidelines, then sign the acknowledgement at the bottom of this page and return it to our office. Our treatment relationship is a partnership and we look forward to helping you achieve the best health outcomes possible.

First Time Visit: Please arrive at least 10 – 15 minutes prior to your appointment time. A nurse will go over your past medical history. Please bring all of your medications in their original containers. If you have co-pay or have not yet met your deductible, please be prepared to pay it when you check in at the front desk. Payment is due at the time of service.

Follow-Up Visits: Please arrive 5 – 10 minutes before your schedule appointment time. It is our goal for you to be ready to see your physician on time. Notify us if you have any changes in your insurance or contact information. Please make us aware of any significant updates in your medical history, such as hospital or urgent care visits, and any changes in your medications by another healthcare provider.

Follow-up Care: Your treatment plan may involve follow-up care. As such, we may schedule you for diagnostic tests, follow-up appointments with us or other providers. If you do not keep the appointment, it is important that you contact us to discuss alternatives. Likewise, if you decide to seek care from another provider, please let us know. It is our policy to inform you of test results, however, if you have not received your test results within the expected time, please contact our office.

Late Arrivals: We all run late sometimes. In the event that you are late for your appointment, we will try our best to work you back in to the schedule. Depending on how busy we are, you may be required to reschedule your appointment.

Appointment Cancellations: We understand that sometimes plans change. We ask that you reschedule appointments *at least* 24 hours in advance so that we may give that time to someone else. Although unexpected events may necessitate missing an appointment, if you miss 1 appointment without following the cancellation protocol then you will be charged $25.00. If

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you miss 3 appointments without following the cancellation protocol, you may be dismissed from the practice. You will receive a written notification after 2 missed appointments.

Sick Visits: Established patients who need acute care should call as early in the day as possible so that we can accommodate you. Patients are seen by appointment only. Depending on the availability of your physician, you may be asked to see another provider.

After Clinic Hours and Weekends: You may reach the on-call physician by calling 770-972-0330 and our after-hour service center will assist you in reaching the on-call physician.

Bringing Children to your Appointment: For safety reasons, children under 5 years of age must be supervised at all times while in our office. There are areas of our office such as the lab and procedure rooms where safety standards apply and we are unable to allow children to accompany you without another supervising adult. Please plan ahead.

We respectfully request that you turn off or silence your cell phone during your office visit.

I have read and understand the above office policies and agree to abide by them.

_____ _____

Name **Date**

1700 Tree Lane · Suite 290 · Snellville, Georgia 30078
Phone: 770/972-0330 · Fax: 770/985-2683 · www.gwinnettobgyn.com

Gwinnett OB/GYN Associates, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name_____

Address: _____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed and a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

  _____

- Other: _____

  _____

Prepared by: _____
Signature: _____
Date: _____

Gwinnett OB/GYN Associates, P.C.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact the Privacy Officer: The Practice Administrator at (770) 972-0330

Effective Date: April 14, 2003 **Revised: September 4, 2013**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new or revised Notice in our office or on our website: gwinnettobgyn.com
- If requested, making copies of the new Notice available in our office or by mail.

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following: Billing companies, Insurance companies, Health plans, Government agencies in order to assist with qualification of benefits and/or Collection agencies.

Example: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use of disclose, as needed, your PHI in order to support the business activities of this practice which are called health care operations

Examples: Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.

Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.

We may also use your information to assist in resolving problems or complaints within the practice.

We may use of disclose your PHI in other situations without your permission:

If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.

Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.

Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.

Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.

Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.

Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.

Correctional Institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use of disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures for any purposes which require the sale of your information
- Release of psychotherapy notes: Pshchotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. A records release form is available in our office or on our website (gwinnettobgyn.com) for you to complete, date and sign, in order to get a copy of your records.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based free for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use of disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. if we agree to a restricted request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: We must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.

You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Gwinnett OB/GYN Associates P.C. ATTN: Privacy Officer, 1700 Tree Lane Rd, Suite 290, Snellville, GA 30078 or you may also complain to the United States Secretary of Health and Human Services, HHS.gov. or at the Georgia Composite Medical Board, Enforcement Unit, 2 Peachtree Street, N.W., 36th Floor, Atlanta, Georgia 30303, medicalboard.georgia.gov.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on September 4, 2013 and/or you may have previously signed on a form dated, April 14, 2003 that will be replaced by the posting of this form.

Gwinnett OB·GYN
ASSOCIATES, P.C.

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Name: _____ **Date:** _____

Date of Birth: _____

Contact Phone Number: _____

Have you traveled outside the United States in the past 12 weeks?

Yes _____ **No**_____

If yes, where? _____ **When?** _____

Have you traveled outside the country at any time during this pregnancy?

Yes_____ **No**_____

If yes, where? _____ **When?** _____

Has/Have your partner(s) traveled outside the United States during your pregnancy?

Yes_____ **No**_____

If yes, where and when?_____

The CDC is recommending against travel to any South or Central American countries including the Caribbean and Mexico during pregnancy.

If you answered to any of the above questions "yes", please discuss with the physician or nurse practitioner at your visit today.

Despite the above recommendation, if you are planning to travel to the above areas you need to notify your OB providers.

Signature_____ **Date:** _____

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