ATLANTA PREMIER OB/GYN ASSOCIATES

Date: ______________ SSN: ______________________ D.O.B: ____________________________

Patients Name: ____________________________________ Phone: ____________________________

Address: ______________________________ City______________State_____Zip_____________

Marital Status:___________ Email____

Employer: ____ Phone: _______________________

Primary Insurance Company: ____

Primary Care Physician: ______________________________ Phone: __________________________

WHO SHOULD WE THANK FOR YOUR REFERRAL?____

In Case of emergency who should we contact?

Name_______________________________________Phone____________________________________

Medical Records Release Authorization

I authorized Atlanta Premier OB/GYN Associates, PC to release to my insurer any medical information necessary to obtain payment of medical benefits under my health insurance

Benefit Assignment Authorization

I authorize my insurer(s) to pay Atlanta Premier OB/GYN Associates, PC any medical benefits due to me or my dependents under health insurance services rendered by Atlanta Premier OB/GYN Associates, PC

Financial Obligation Acknowledgement

I understand that I am responsible to pay Atlanta Premier OB/GYN Associates, PC for services rendered to me or my dependents if payment of assigned benefits under my health insurance is denied or not paid within a reasonable length of time by my insurer(s)

Authorized Signature ____ Date: ____________________

Medicare Advance Beneficiary Notice (ABN)

I have been informed that Medicare will only pay for services deemed to be "reasonable and necessary" under section 1862 (a) (1) of the Medicare Law. In the event Medicare denies payment. I agree to be personally responsible for payment

Medicare Beneficiary Signature: ________________________________ Date: ____________________

Atlanta Premier OB/GYN Associates, PC

Name ______________________________ DOB ______________

LMP ____________ normal abnormal Explain ______________________

Medical Problems ______________________________________

Past Surgeries ______________________________________

Allergies ______________________________________

Medications ______________________________________

Tobacco ____________ Alcohol ____________ Drugs(any) ____________

Sexually active ____________ protected unprotected

Sexual partner: Male Female Both Number of lifetime partner ____________

Ever have any sexually transmitted infections ______________________

How many pregnancies ______ How many births ______ How many abortions/miscarriages ______

Any problems with pregnancies ______________________________

Last pap ____________ normal abnormal

Last mammogram ____________ normal abnormal

Last colonoscopy ____________ normal abnormal

Any history of abuse (physical, sexually) ______________________

Any medical problems run in your family

____

____

Do you have concerns/problems with your current weight ______________________

Do you have concerns/problems with sex ______________________

Do you have concerns/problems with BV or odor ______________________

Atlanta Premier OB/GYN Associates, PC

In an effort to provide the best experience during your office visit today and help us keep current on your health, please take a few minutes to complete the following questions. Thanks you!

Name____ Date____________________

CONTRACEPTION

1. What is your current form of birth control?

2. How long have you been using your current form of birth control? *(please check one)*
   ___Two years or less ___3 to 5 years ___6 to 10 years ___Over 10 years

3. When are you planning to have another child? *(please check one)*
   ___Within the next year ___Within the next 5 years
   ___Within the next 10 years ___My family is complete

4. Would you like information on a non-surgical, hormone-free permanent birth control procedure performed in the comfort of our office?

MENSTRUAL PERIODS

1. How long does your average monthly period last? _________Days

2. Do you ever feel as though your periods impact the quality of your life? __Yes __No

3. Do you experience irregular, inconsistent, or heavy bleeding? __Yes __No

4. Are you periods painful? __Yes __No

5. Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods? __Yes __No

Atlanta Premier OB/GYN Associates, PC

New Patient Intake Form

1. Do you have regular monthly periods? ______________________________
2. How many days do your periods last? ______________________________
3. How may pads/tampons do you use in a day? ______________________________
4. Do over-the-counter medications improve your pain with your period?____________
5. Do you urinate (pee) on yourself when you cough, laugh or sneeze? ____________
6. Are you interested in having more children? ______________________
7. Do you have regular or constant pelvic pain? ______________________________
8. Do you feel like you always have yeast infections?______________________________
9. Do you have pelvic pain after intercourse? ______________________________
10. Do you have vaginal pain after intercourse? ______________________________
11. Do you have spotting/bleeding after intercourse? ______________________________
12. Do you feel like you always have bacterial vaginitis? ______________________________
13. Do you have persistent vaginal odor? ______________________________

Atlanta Premier OB/GYN Associates, PC

CONSENT FOR HIV TESTING

Please initial your choice and sign below.

_____ **I authorize** the doctor's office to test me for HIV, the virus that causes Acquired Immunodeficiency Syndrome (AIDS) and related syndromes.

In signing this consent form, I acknowledge that I have been offered and/or provided with information about this test, about the HIV virus and about AIDS. I have been given the opportunity to ask questions regarding this information and my questions have been answered.

I have been informed that both my request for the HIV test and the test results are considered confidential and will be released only to me except as required or permitted by law.

If the test results are positive, I will be provided information about the consequences for my own health care so that I might take precautions to prevent transmission of the virus to others.

I understand that Georgia law requires the reporting of confirmed positive test results to the Public Health Department.

I understand that, unless otherwise limited by state and federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

_____ **I do not authorize** blood collection for HIV antibody testing.

______________________________ ______________________________
Signature of Employee Signature of Witness

Date ______________________________

I have consulted with the above mentioned person about testing him or her for HIV, about the availability and necessity of post-testing counseling, and that test results will be handled confidentially as prescribed by law.

_______ ______________________________
Date Signature of Physician

Atlanta Premier OB/GYN Associates, PC

5835 Campbellton Rd, Suite 105

Atlanta, GA 30331

Phone (678)705-4900

Fax (678) 705-5441

Authorization for Release of Information

The patient listed below has authorized the release of medical information from ____. Please forward the following medical records for the patient.

____ Progress Notes
____ Labs/Cytology/Pathology/Radiology
____ Correspondence
____ H&P

Patients Name____

DOB___________________

Patients Signature ____

**************STAT REQUEST---PATIENT IN THE OFFICE*******************

MISSED APPOINTMENT and CANCELLATION POLICY

If you are unable to keep a scheduled appointment, please give 24 hours advance notice to ensure that you will not be charged for the appointment.

If less than 24 hours' notice is given you will be CHARGED A $25.00 CANCELLATION FEE.

Patient Name____

Sign______________________________ Date_____________

Family History of Cancer Questionnaire

Name______________________________ **Date of Birth** ________________

Please circle Y to those that apply to **YOU** **and/or** **YOUR FAMIL Y** (on both **MOTHER** and **FATHER'S** side.)
Please list your relationship to the individual diagnosed and the age at cancer diagnosis.

Consider PARENTS, SIBLINGS, GRANDPARENTS, AUNTS, UNCLES, NIECES, & NEPHEWS

HEREDITARY BREAST and OVARIAN CANCER SYNDROME

		Relationship	Age at Diagnosis
Breast cancer before age 50	Y N	__________	________
Ovarian cancer at any age	Y N	__________	________
Breast cancer in both breasts or multiple primary breast cancers at any age	Y N	__________	________
Male breast cancer at any age	Y N	__________	________
3 or more breast cancers on the same side of the family at any age	Y N	__________	________
Ashkenazi Jewish with a personal or family history of breast or ovarian cancer at any age	Y N	__________	________

LYNCH SYNDROME / HEREDITARY NONPOLYPOSIS COLORECTAL CANCER

Endometrial (uterine) cancer before age 50	Y N	__________	________
Colorectal cancer before age 50	Y N	__________	________
Colorectal or endometrial cancer at any age AND another family member on the same side of the family with any cancer listed below at any age:	Y N	__________	________

Colorectal, Endometrial, Ovarian, Stomach, Pancreatic, Kidney/ Urinary Tract, Brain, or Small Bowel

If you circled yes to one or more statements on the Family History Questionnaire, you may be appropriate for a blood test to help determine if you have an inherited risk of cancer.

FOR OFFICE USE ONLY

O Patient offered genetic testing
O **Accepted** O **Declined**
O Not applicable/ Patient does not meet criteria

O Information given to patient for review
O Follow up appointment scheduled for date __________

Physician Signature________________________ Date: ____________