

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 many 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

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 FAMILY** (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

		<u>Relationship</u>	<u>Age at Diagnosis</u>
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

<input type="checkbox"/> Patient offered genetic testing <input type="checkbox"/> Accepted <input type="checkbox"/> Declined <input type="checkbox"/> Not applicable/ Patient does not meet criteria	<input type="checkbox"/> Information given to patient for review <input type="checkbox"/> Follow up appointment scheduled for date _____
Physician Signature _____ Date: _____	