SAVANNAH OB/GYN, PC

Heart & Lung Building
5356 Reynolds Street, Suite 410
(912) 355-8136

Alan E. Smith, M.D., F.A.C.O.G.
Amy C. Burgett, M.D., F.A.C.O.G.
Angelyn Dekle, RN MSN FNP
Melanie L. Howard, RN MSN FNP

Life Care Building
5353 Reynolds Street, Suite 300
(912) 355-4408

Ashley Hunsuck, M.D.
Elizabeth McIntosh, M.D.
Sarah Jarrell, M.D.
Lawrence N. Odom, M.D.
Glen L. Scarbrough, M.D.

Welcome to Savannah OB/GYN, P.C. We're glad you've chosen our practice to receive your obstetrical care.

This is to confirm that _____ has an appointment with

_____ on _____ at _____.

If the date or time for the appointment does not work well with your schedule, please give our office a call. Our office requires a 24 hour notification if you are not going to be able to make it to your scheduled appointment; or you could be charged a $25 No Show fee.

Please arrive 30 minutes early to your appointment in order to ensure that your information is entered into our system in a timely manner. If you are more than **15 minutes late** for your appointment, we may work you in as the schedule permits or reschedule the appointment for another day. Also, please call if you think you are going to be late for your visit so that we can adjust the schedule accordingly.

To insure speedy check in time, we ask our new patients to do the following:

1. Please fill out the enclosed new patient information packet and bring it with you to your appointment.
2. Please bring your **insurance cards,** a **picture ID,** and a **current list of meds.**
3. If you are a transfer patient, please bring any medical records from your previous doctor. If you are having difficulties trying to obtain your medical records, please notify our office prior to your appointment.
4. Please be on time to your appointment, and remember that your first visit with us may take longer than your follow up appointment, please allow for this in your schedule.
5. **PLEASE COMPLETE ALL SECTIONS OF THIS PAPERWORK PRIOR TO YOUR APPOINTMENT.**

Again, thank you for electing to see one of our healthcare providers and we hope your experience with our office will be very pleasurable. If you have any questions or concerns, please feel free to call us.

Savannah OB/GYN, P.C.

PATIENT REGISTRATION

Last Name: _____ First Name _____ MI _____

SSN: _____ Sex: _____ Date of Birth _____/_____/_____ Marital Status _____

Address _____ APT _____

City _____ State _____ ZIP _____

Home # _____ Work # _____ Cell # _____

Email _____ Primary Care Physician _____

Employer _____

Employer's Address _____

IF PATIENT IS A MINOR OR DEPENDENT, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Responsible Party _____ Relation to Patient _____

Home # _____ Work # _____ Cell # _____

PRIMARY INSURANCE (A COPY OF YOUR INSURNACE CARD IS REQUIRED)

Insurance _____ ID _____ Group _____

Insured's Name _____ Insured's Date of Birth _____/_____/_____

Social Security Number _____ Relation to Patient _____

Employer Name _____

SECONDARY INSURANCE (A COPY OF YOUR INSURNACE CARD IS REQUIRED)

Insurance _____ ID _____ Group _____

Insured's Name _____ Insured's Date of Birth _____/_____/_____

Social Security Number _____ Relation to Patient _____

Employer Name _____

EMERGENCY CONTACT

Name _____ Relation to Patient _____

Home # _____ Work # _____ Cell # _____

CONSENT FOR TREATMENT

The signature below serves as consent for services/treatment/referrals to be rendered by Savannah OB/GYN for the above named patient. This also authorizes the practice to release or receive protected health information for the purpose of treatment, payment, or health care operations necessary for such services.

_____ _____

Patient (or legal guardian) signature Date

_____ _____

If legal guardian, print name Relation to patient

Name: _____ **Date of Birth**: _____

Savannah OB/GYN, PC

This is a confidential record of your medical history and will be kept secure in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Current Pharmacy: _____

Reason for Visit: _____

Medical History – Please indicate if you have any of the following medical conditions, even in the past. If you answer "yes", please tell us who your doctor was and where you were treated.

Epilepsy/Seizure Disorder	Yes ☐ No ☐	Joint Pain/Injury	Yes ☐ No ☐
Migraine Headache	Yes ☐ No ☐	Breast Biopsy/Lumpectomy	Yes ☐ No ☐
Cluster Headache	Yes ☐ No ☐	Breast Cancer	Yes ☐ No ☐
Seasonal Allergies/Sinus Infection	Yes ☐ No ☐	Rheumatoid Arthritis	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Lupus	Yes ☐ No ☐
Bronchitis	Yes ☐ No ☐	Autoimmune Disorder (other)	Yes ☐ No ☐
Pneumonia	Yes ☐ No ☐	Clotting Disorder	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	Easy Bruising	Yes ☐ No ☐
Blood Clot (DVT or PE)	Yes ☐ No ☐	Sickle Cell Disease	Yes ☐ No ☐
Heart Attack	Yes ☐ No ☐	Anemia	Yes ☐ No ☐
High Blood Pressure	Yes ☐ No ☐	Chicken Pox	Yes ☐ No ☐
High Cholesterol	Yes ☐ No ☐	Blood Transfusion	Yes ☐ No ☐
Heartburn/GERD	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐
Gallbladder Disease	Yes ☐ No ☐	Thyroid Disorder	Yes ☐ No ☐
Liver Disease	Yes ☐ No ☐	Other Endocrine Disorder	Yes ☐ No ☐
Hepatitis	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Chrohn's or Ulcerative Colitis	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Constipation	Yes ☐ No ☐	Other Infectious Disease	Yes ☐ No ☐
Diverticulitis	Yes ☐ No ☐	Depression	Yes ☐ No ☐
Kidney Disease	Yes ☐ No ☐	Bipolar Disorder	Yes ☐ No ☐
Kidney Stones	Yes ☐ No ☐	Anxiety	Yes ☐ No ☐
Frequent UTIs (>3 per year)	Yes ☐ No ☐	ADHD/ADD	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Substance Abuse/Alcoholism	Yes ☐ No ☐
Chronic Back Pain	Yes ☐ No ☐	Eating Disorder	Yes ☐ No ☐
Irritable Bowel Syndrome	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐
Nausea	Yes ☐ No ☐	Frequent Sore Throat	Yes ☐ No ☐
Vomiting	Yes ☐ No ☐	Burning in Urination	Yes ☐ No ☐
Diarrhea	Yes ☐ No ☐	Frequent Urination	Yes ☐ No ☐
Vomiting Blood	Yes ☐ No ☐	Blood in Urine	Yes ☐ No ☐
Shortness of Breath	Yes ☐ No ☐	Urgency/Leak of Urination	Yes ☐ No ☐
Chest Pain	Yes ☐ No ☐	Herpes	Yes ☐ No ☐
Palpitations (heart races)	Yes ☐ No ☐	Sexually Transmitted Diseases	Yes ☐ No ☐

Please explain "yes" answers in detail along with treating physician, or add conditions not listed:

_____

_____

_____

Name: _____ Date of Birth: _____

ALLERGIES/SENSITIVITIES – Please list your allergies to medications, food or other substances, including reaction:

Substance/Medication	Reaction	Date

ANESTHESIA – Do you or any family member have a history of problems with anesthesia? *YES ☐ NO ☐

*If yes, please describe: _____

SURGICAL HISTORY – Please list any surgeries you have had along with the date and the name of the doctor who preformed the surgery. (For example: appendectomy, cesarean delivery, knee surgery, etc.)

Date/Year	Surgery	Reason preformed/Diagnoses	Surgeon

MEDICATIONS – Please provide a complete list of all your medication, vitamins, and dietary supplements including dose:

Date Started	Med/Vitamin/Supplement	Dose	Prescribed by:

Name: _____ Date of Birth: _____

MENSTRUAL AND GYNECOLOGIC HISTORY:

1. How old were you when you first started your period? _____
2. What was the first day of your last menstrual period (if unsure, best guess)? _____
3. Duration of period/bleeding: _____ days
4. Time in between cycles: _____ days
5. Are you currently using a method of birth control? *YES ☐ NO ☐

   If yes, what method(s)? _____
6. Bleeding or spotting between periods? YES ☐ NO ☐
7. Have you had problems with any of the following during your periods in the past (circle all that apply)?

   Heavy Bleeding Passing Clots Painful Periods Irregular Periods

   Skipping Periods Mood Swings Irritability Unable to preform normal tasks

   Other: _____
8. Sexually Transmitted Disease? *YES ☐ NO ☐

   * If yes, were you ever hospitalized or followed up? _____
9. Infertility or difficulty getting pregnant? *YES ☐ NO ☐

   *If yes, please explain: _____

SOCIAL:

Primary Language Spoke: _____

Significant Others Name: _____

Are you currently sexually active? YES ☐ NO ☐

Have you ever/currently experiencing: Sexual Abuse Physical Abuse Emotional/Verbal Abuse

How many times a week do you exercise? _____

Do you have an indoor OR outdoor cat? _____

DIAGNOSTIC STUDIES/SCREENING – Please indicate if you have had any of the following health screening. If yes, please tell us the date, why the test was done, and the results:

		Date	**Reason for test**	**Results**	**Physician**
DEXA (Bone Density) Scan	YES ☐ NO ☐				
Cholesterol (Lipid Panel)	YES ☐ NO ☐				
Colonoscopy	YES ☐ NO ☐				
Mammogram	YES ☐ NO ☐				
Pap Smear	YES ☐ NO ☐				
Other: _____					

VACCINATION HISTORY – Please circle which vaccines you have received and date, if known:

Hepatitis A	Hepatitis B	Cervarix	Measles/Mumps/Rubella	H1N1 Flu
Tetanus	Chicken Pox	Pneumovax	Pertussis	Other _____
Meningitis	Zostavax (Shingles)	Seasonal Flu	Gardasil	

OBJECTIONS – Do you have any personal or religious objections to any form of medical treatment (i.e. refusal of blood transfusion)? *YES ☐ NO ☐

*If yes, please describe: _____

_____

OBSTETRICAL HISTORY:

Total Pregnancies: _____ Full-Term Pregnancies: ___ Premature: _____ Abortions: _____
Miscarriages: _____ Ectopic: _____ Multiple Births: _____
How many living children do you have? _____
Will you be 35 years or older at the time this baby is born? YES ☐ NO ☐

PREVIOUS PREGNANCIES:

Date	Weeks Gestation	Type of Delivery	Health of Child	Complications

PERSONAL HISTORY:

1. Do you smoke? YES ☐ NO ☐
    a. How many years have you been smoking? _____
    b. How much per day? _____
2. Do you drink alcohol? YES ☐ NO ☐
    a. How much per week? _____
3. Are you allergic to any drugs? YES ☐ NO ☐
    a. If yes, which ones? _____

FAMILY HISTORY – Does anyone in your family have the following medical conditions? Please circle yes or no and indicate who has the illness and their age at diagnosis if known.

		Mother	Father	Bro/Sis	Other
Ovarian Cancer	Yes ☐ No ☐	☐	☐	☐	☐
Uterine Cancer	Yes ☐ No ☐	☐	☐	☐	☐
Breast Cancer	Yes ☐ No ☐	☐	☐	☐	☐
Colon Cancer	Yes ☐ No ☐	☐	☐	☐	☐
Other Cancer(s)	Yes ☐ No ☐	☐	☐	☐	☐
Stroke	Yes ☐ No ☐	☐	☐	☐	☐
Heart Attack	Yes ☐ No ☐	☐	☐	☐	☐
Blood Clot (DVT or PE)	Yes ☐ No ☐	☐	☐	☐	☐
High Blood Pressure	Yes ☐ No ☐	☐	☐	☐	☐
Diabetes	Yes ☐ No ☐	☐	☐	☐	☐
Inflammatory Bowel Disease	Yes ☐ No ☐	☐	☐	☐	☐
Epilepsy/Seizures	Yes ☐ No ☐	☐	☐	☐	☐
Depression	Yes ☐ No ☐	☐	☐	☐	☐

FAMILY GENETICS HISTORY (CONTINUED) – This pertains to both patient and the father of the baby and his family.

Have you had a child born with a birth defect? YES ☐ NO ☐

*If yes, please describe: _____

Did either you or the baby's father have a birth defect? YES ☐ NO ☐

*If yes, please describe: _____

Please describe any abnormalities that have occurred in the children of your family or the baby's father's family (birth defect, mental handicaps, inherited disease such as hemophilia, muscular dystrophy, or cystic fibrosis:

_____

_____

_____

Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillborn?) YES ☐ NO ☐

*If yes, have either of you had genetic counseling? YES ☐ NO ☐

*If yes, have either of you had chromosomal testing? YES ☐ NO ☐

Where and what were the results? _____

Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:

1. **Eastern Europe Jewish Ancestry:** Mother ☐ Father ☐ Both ☐

   If yes, have you had Tay-Sachs screening test? YES ☐ NO ☐

   If yes, have you had a Canavan Screening test? YES ☐ NO ☐

   Date: _____ Result: _____

2. **African American**: Mother ☐ Father ☐ Both ☐

   If yes, have you had sickle cell screening? YES ☐ NO ☐

   Date: _____ Result: _____

3. **European Ancestry:** Mother ☐ Father ☐ Both ☐

   If yes, have you had cystic fibrosis screening? YES ☐ NO ☐

4. **Mediterranean Ancestry:** Mother ☐ Father ☐ Both ☐

   If yes, have you had screening for inherited forms of anemia such as thalassemia? YES ☐ NO ☐

ATTENTION TO OB PATIENTS:

This is to inform you that some insurance companies do not consider ultra-sounds during pregnancy as medically necessary or limit the number that will be covered during your pregnancy. We cannot anticipate what each plan may cover. It is your responsibility to check your benefits and understand that you are responsible for anything your insurance does not cover.

_____ _____

Patient Signature Date

CONSENT TO ADMINISTER HIV TEST

I, _____, am a patient of Dr. _____.

This physician has informed me that he/she recommends that I receive an HIV blood test in order to facilitate my treatment as well as to protect hospital personnel and other patients.

I have received counseling prior to my entering into consent for this procedure and have been informed that I have the right to refuse this testing. The counseling I have received from my physician consisted of the following:

_____ Information regarding AIDS and HIV. I have received an explanation of behaviors that reduce the risk of transmitting AIDS and HIV, an explanation of the confidentiality of information regarding both social and medical implications of HIV testing and disclosure of commonly recognized treatment or treatments for AIDS and HIV or literature that explains this to me.

I understand that I will be notified of the result of the HIV test and results will be explained to me:

On the basis, I DO ☐ DO NOT ☐ authorize Savannah OB/GYN, P.C., Dr. _____ or anyone authorized by them to preform the HIV blood test.

_____ _____

Date Signature of Patient

_____ _____

Date Witness

_____ _____

Date Physician

Medications Safe to Use During Pregnancy

***Headache, Fever**: Plain Tylenol (Acetaminophen)*

***Antacids:** Tums, Mylanta, Axid, Tagamet, Pepcid (2nd & 3rd trimesters only)*

***Constipation**: Increase in fiber (eating fruits, green leafy veggies, bran cereals) increase fluid intake, decrease sugars, increase physical activity – if not effective: Colace stool Softener, Metamucil, Benefiber, Citrucel, Miralax, Glycerine Suppository, Prune Juice*

***Diarrhea**: pepto-Bismol, Imodium AD (only 3 days)*

***Hemorrhoids**: Preparation H, Anusol cream and suppositories, Witch Hazel pads*

Yeast Infection**: Monistat 7 (Miconazole) **Call if no improvement in 2 days

***Nausea**: Motion Sickness wrist bracelets (Can be purchased at Bass Pro Shops), Ginger, flattened coca cola, Vitamin B6+ Unisom sleep aid, Dramamine, Benadryl*

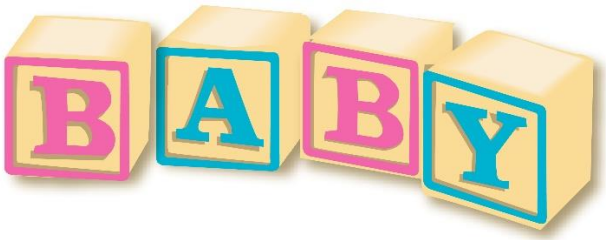
***Rashes**: Benadryl cream, Hydrocortisone cream/ointment, Caladryl lotion, Aveeno oatmeal bath*

***Allergies**: Claritin D, Zyrtec, Flonase*

***Sinus Pain and Pressure**: Plain Sudafed, Nasal Saline nose drops, Netti Pot (purchase at pharmacy), Afrin nasal spray (after 12 weeks – once every 12 hours for no more than 3 days)*

***Cough and Cold:** Robitussin DM, Delsym, Coricidin HBP Cough and Cold (if high blood pressure), Mucinex (chest congestion) Tylenol Cold, Robitussin cough drops, Cepacol throat lozenges (sore throat)*

***Dental Care**: Xylocaine (local anesthesia) is allowed*



If these medication do not relieve your symptoms or if you develop a fever greater than 100.4° F, notify your physician.

Patient Contact Information

Patient Name _____ Date of Birth _____/_____/_____

Contact Name _____ Relationship _____

Phone Number 1: _____ Phone Number 2: _____

Full Disclosure

I, _____, hereby grant permission for Savannah OBGYN, PC to contact, disclose and discuss my health information with the person named above. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") which became effective April 14, 2003.

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____

Appointments Only

I, _____, hereby grant permission for Savannah OBGYN, PC to contact, disclose and discuss my health information relating to appointments only; requesting, changing and canceling with the person named above. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and accountability Act of 1996 ("HIPAA") which became effective April 14, 2003.

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____

Insurance and Billing Only

I, _____, hereby grant permission for Savannah OBGYN, PC to contact, disclose and discuss my health information relating to insurance and billing issues with the person named above. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and accountability Act of 1996 ("HIPAA") which became effective April 14, 2003.

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____

Decline

I, _____, **decline** permission for Savannah OBGYN, PC to disclose any of my health information.

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____

Nutrition for Nausea and Vomiting During Pregnancy

Nausea and vomiting symptoms are extremely common during the first three months of pregnancy due to changing hormones. The following are some suggestions to help with these symptoms.

- Symptoms seem more pronounced when the stomach is empty. Eating frequently (every 1 ½ – 2 hours) in small amounts will keep the nausea to a minimum.
- Separate liquids from solid foods – if you drink something, don't eat for at least 30 minutes.
- Carbohydrates and starches are the most popular foods.
- High fat, spicy, or gaseous foods are not tolerated well.
- Citrus fruits and drinks usually have too much acid.
- Vitamins are important. If you can tolerate prenatal vitamins, they should be taken daily with solid foods.
- Folic acid (0.4-1 mg average) is recommended daily. This is available in the prenatal vitamins or may be taken separately.
- Centrum or two children's chewable vitamins may be taken daily if other vitamins cannot be tolerated.
- Vitamin B-6, 50-100mg twice daily or vitamin B-6, 25mg four times every day can decrease nausea (must take 2 times every day).
- Motion sickness or sea sick bands can be purchased at drug stores.
- Keep some type of dry food next to your bed if you get up during the night or when you wake up in the morning.
- Try eating lemon drops, mints, and foods and drinks containing ginger (i.e. ginger ale, ginger snaps).

Some women require prescription medication or hospitalization if symptoms are severe. Please feel free to call if vomiting is excessive.

SOME POPULAR FOOD AND DRINK IDEAS

Food	Drinks
Saltine Crackers	Milk Shakes
Dry Cereals – Cheerios/Rice Chex	Ginger Tea
Toast/Graham Crackers	Hi-C Punch
Rice/Noodles/Baked or Boiled Potatoes	Ginger Ale
Bagels – Plain or with Cream Cheese	7-Up
Oodles of Noodles	Sprite
Toast/Cheese Toast	Coke
Macaroni and Cheese	Grape Juice
Peanut Butter	Papaya Juice
Scrambled Eggs	Apricot Juice
Peeled Apples/Apple Sauce/Watermelon	Apple Juice
Sherbert/Ice Pops	Gatorade
Oatmeal/Grits	Lemonade
Pretzels/Pop Corn	
Ginger Snaps	
Tuna/Chicken – Baked or Grilled	

PEDIATRICIAN LIST

BE PEDIATRICS

410 Mall Blvd, Ste 3,
Savannah, GA 31406
912-472-0314

Linda Winders, MD
Kasey Berman, MD

COASTAL PEDIATRICS

2 Wheeler St
Savannah, GA 31405
912-353-7744

1000 Towne Center Blvd
Pooler, GA

Kelsey Alexander, MD
Melissa Behm, MD
Richard Callan, MD
Dudley Stone, MD

CURTIS COOPER HEALTH CENTER

106 East Broad St
Savannah, GA 31404
912-527-1000
Greer Larned, MD
Fariborz Zaer, MD
Yael R. Elfassy, MD

GEORGIA PEDIATRICS

322 Stephenson Ave
Savannah, GA 31405
912-354-3130
Robert Cossio, MD

KIDS FIRST PEDIATRICS OF GA

101 Little Neck Road, Ste 2A
Savannah, GA 31419
912-920-2379

Francisco Herran, MD
Yolanda Rivera-Caudill, MD

DOUGLAS MARIRLA

304 Stephenson Ave
Savannah, GA 31405
912-692-1181

MEMORIAL PEDIATRICS

4849 Paulsen Street, Ste 208
Savannah, GA 31405

Willie Ester McAlpine, MD 912-349-3682
Charlene Sojico, MD 912-353-9494

PED'S HEALTH

361 Commercial Drive, Ste B
Savannah, GA 31406
912-777-5490

Ericka Russell-Petty MD

SOUTHCOAST PEDIATRICS – RICHMOND HILL

1055 Ford Ave, Ste 4A
Richmond Hill, GA 31324
912-527-5352

Larry Elam, MD
William Webb, MD
Keith Siebert, MD
Blaine Crosland, MD

SOUTHCOAST PEDIATRICS - RINCON

814 Towne Park Drive, Ste 100
Rincon, GA 31326
912-826-4866

Amanda Hendricks, MD
Jami Scanlon, DO

SOUTHCOAST PEDIATRICS - SAVANNAH

310 Eisenhower Drive, Bldg #16
Savannah, GA 31406
912-303-3500
Robert Jones, MD
David Mozer, MD
Micah Riegner, MD

EFFINGHAM FAMILY MEDICINE

1451 Hwy 21
Springfield, GA 31329
912-772-8620

Bailey Alford, MD

PEDIATRIC ASSOCIATES OF SAVANNAH

4600 Waters Ave #100, Savannah, GA 31404
110 Medical Park Drive, Pooler, GA 31322
1001 Memorial Dr, Savannah, GA 31410
912-355-2462

Michael DeMauro MD, Brandy Gheesling MD, John Hobby MD, Paul Nave MD, Chintak Patel MD, Giselle Rosinia MD, Diane Savage-Pedigo MD, Benjamin Spitalnick MD, Andria Wilkes MD, Christopher Rogers MD, Carly Ryan MD