SAVANNAH OB/GYN, PC

Heart & Lung Building
SJC – Candler Hospital campus
5356 Reynolds Street, Suite 410
(912) 355-8136

Alan E. Smith, M.D.
Sarah B. Skinner, M.D.
Angelyn Dekle, RN MSN FNP
Melanie L. Howard, RN MSN FNP
Leah Marks, RN, MSN, FNP

Life Care Building
SJC – Candler Hospital campus
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.
Gretchen Eichenlaub, RN MSN WHNP
Courtney Pierre, RN MSN WHNP
Morgan Whelan, RN MSN WHNP

Welcome to Savannah OB/GYN, P.C.!

We are dedicated to providing compassionate, confidential, and comprehensive care to women at all stages of life.

Your appointment has been scheduled for _____ at _____

with _____

Please read and follow these instructions before your appointment:

1. **Arrive AT LEAST 15 minutes early** for check-in and information verification.
   To ensure the best first visit experience, **PLEASE COMPLETE THE ATTACHED FORMS**.

2. Bring:
   - Photo ID
   - Insurance Card
   - Medications
   - If you are a transfer patient, please bring medical records from your previous doctor. If you are having difficulty securing your records, please contact our office prior to your appointment.

3. If you are currently on your period on the day of your appointment, please notify the office.

4. Notify us if you are pregnant or may be pregnant.

We kindly ask that you give at least a 24-hour notice if you are unable to keep your scheduled appointment. This will give us ample time to schedule someone else who may need an urgent same day appointment. If you are *more than 15 minutes late* for your appointment, we reserve the right to reschedule your appointment. Failure to cancel or keep your new patient appointment may result in declining to schedule future appointments.

Again, thank you for electing to see one of our healthcare providers and we hope your experience with our office will be very pleasurable.

Preferred Laboratory Services

For your convenience, Savannah OBGYN has partnered with two reputable outsourced laboratories to provide primary outsource laboratory services at our office locations.

Even though these laboratories participate as an in-network laboratory service with most insurance companies, we require that **you** verify the "*preferred lab*" with your insurance company *prior to your appointment*.

We also offer lab draw services for those who have medical insurance with St. Joseph's/Candler Health System.

Please know that Savannah OB/GYN will not be held financially responsible for primary outsourced laboratory testing and/or services NOT COVERED by your medical insurance plan.

It Is important for you to know your medical insurance plan's preferred lab, in-network providers and in-network hospital.

Please select the office location for your appointment:

5353 Reynolds St. Ste. 300 – Life Care Office

☐ **Labcorp** (Primary Outsource Lab)

☐ **St. Joseph/Candler Laboratory Outreach Services**
* Preferred for SJC employees/dependents (drawn in office but sent to SJC Laboratory for processing)

☐ **Other** _____

5356 Reynolds St. Ste. 410 – Heart and Lung

☐ **PathGroup Laboratory** (Primary Outsource Lab)

☐ **St. Joseph/Candler Laboratory Outreach Services**
* Preferred for SJC employees/dependents (drawn in office but sent to SJC Laboratory for processing)

☐ **Other** _____

In signing this form, you have read the above and designated your laboratory testing to be sent to the "preferred lab" as noted by your medical insurance plan.

Patient Name: _____

Patient Signature: _____

Date: _____

SAVANNAH OB/GYN, PC

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Sarah C. Jarrell, MD • Lawrence N. Odom, MD • Glen L. Scarbrough, MD
Life Care Office (912) 355.4408 / Heart and Lung Office (912) 355-8136

Patient Name: _____ DOB: _____ ID: _____

Patient Code of Conduct

Savannah OBGYN is a healing, nurturing and supportive environment. To accomplish our mission to improve the lives of women, we need to work together to ensure a safe and healthy environment for our patients, visitors and staff. Savannah OBGYN expects all patients, visitors and accompanying family members to show respect to one another by refraining from unacceptable behaviors that are disruptive or pose a threat to the rights and safety of others.

As a patient visiting our practice, we request the following:

- Please communicate all issues you wish to discuss with your provider at the time your appointment is scheduled so we can allot an appropriate amount of time for your appointment. If additional time is required, another visit may be necessary to ensure all patients are given the time and quality of care they deserve.
- If you need to CANCEL or RESCHEDULE an appointment, please contact our office **at least 24 hours prior to your appointment.**
- If you have any questions about the care you received or if you are unhappy with the care you received, please contact our practice manager before you leave the office.
- We have a **ZERO TOLERENCE** policy for any aggressive behavior directed toward our staff. We encourage you and your support team to be respectful to your care team.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with our staff, please put your device away after completing check-in.
- Please supervise underage children accompanying you.
- End every visit with a clear understanding of your provider's expectations and treatment goals.
- Follow recommended treatment plans, consultations, and other follow-up care.

The following behaviors are prohibited:

- Possessing weapons, i.e. firearms
- Intimidating, harassing, physically assaulting, or threatening staff or other patients or visitors including use of profanity or aggressive behavior.
- Making threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal, or electronic communication.
- Damaging business equipment or property.
- Making menacing or derogatory gestures.
- Making racial, cultural, or sexual slurs or other derogatory remarks.
- Videotaping, audiotaping, or recording Savannah OBGYN providers, staff members, patients, or visitors by any other means without prior authorization.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report it to any staff member. Violators are subject to removal from the facility and/or discharged from the practice.

Patient Signature; _____ Date: _____

SAVANNAH OB/GYN, PC

Heart & Lung Building
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OBTAIN MEDICAL RECORDS

To: _____

Fax # _____

Address: _____

_____

RE: Patient's Name _____

Date of Birth _____

SSN # _____

Patient's Address _____

_____

I request that all my medical records be released to the following:

Savannah OB/GYN, P.C.
5356 Reynolds Street, Suite 410 • 5353 Reynolds Street, Suite 300
Savannah, GA 31405

I place no limitation on history or illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, HIV test, or psychiatric disorders.

This authorization can be revoked, but not retroactive to the release of information made in good faith.

_____ _____

Date Signature of Patient (or guardian)

_____

Relation to Patient (if applicable)

SAVANNAH OB/GYN, PC

Alan E. Smith, MD • Sarah B. Skinner, MD • Ashley Hunsuck, MD • Elizabeth McIntosh, MD • Sarah Jarrell, MD • Lawrence Odom, MD • Glen Scarbrough, MD

Authorization for Release of Health Information

This form applies only to the release and disclosure of your health information to another medical provider. It is not intended for any other purpose. By signing this form, I authorize: Savannah OB/GYN, PC to RELEASE protected health information needed for my treatment TO:

PROVIDER NAME: _____

ADDRESS: _____

PHONE NUMBER: _____ FAX NUMBER: _____

Note: This authorization expires upon fulfillment of request.

I authorize copies of my medical records to be RELEASED by DR: _____

Savannah OB/GYN, P.C.
5356 Reynolds Street, Suite 410 • 5353 Reynolds Street, Suite 300
Savannah, GA 31405

I understand that this information may include any history of or references to acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV); behavioral health/psychiatric care, treatment for alcohol and/or drug abuse; or similar conditions. I understand that Savannah OB/GYN assumes no responsibility for the subsequent use/misuse by others of my health information which was disclosed under this authorization. I release Savannah OBGYN from all legal liability that may arise from release of my information under this authorization.

PATIENT SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ DOB: _____

If the signature above is not that of the patient, I am acting for the patient because:

_____

Relationship: _____ Signature: _____

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

Patient Contact Information - HIPAA

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 _____

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 ☐	Palpitations (heart races)	Yes ☐ No ☐
Diarrhea	Yes ☐ No ☐	Burning in Urination	Yes ☐ No ☐
Vomiting Blood	Yes ☐ No ☐	Frequent Urination	Yes ☐ No ☐
Shortness of Breath	Yes ☐ No ☐	Blood in Urine	Yes ☐ No ☐
Chest Pain	Yes ☐ No ☐	Urgency/Leak of Urination	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

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 performed/Diagnoses	Surgeon

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 ☐	☐	☐	☐	☐

Name: _____ Date of Birth: _____

MENSTRUAL AND GYNECOLOGIC HISTORY:

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

   If yes, what method(s)? _____
5. Number of pads/tampons used on heaviest day: _____
6. Bleeding or spotting between periods? YES ☐ NO ☐
7. Do you have problems with any of the following during your period (circle all that apply)?

   Heavy Bleeding Passing Clots Painful Periods Irregular Periods

   Skipping Periods Mood Swings Irritability Unable to perform normal tasks

   Other: _____
8. Vaginal Discharge? YES ☐ NO ☐

   If yes: Color: _____ **AND** Odor? YES ☐ NO ☐ **AND** Worse BEFORE ☐ AFTER ☐ menstrual period
9. In the last two years, have you missed more than three menstrual cycles at one time? YES ☐ NO ☐
10. Have you ever had an abnormal PAP smear? YES ☐ NO ☐
11. Bleeding or spotting after sexual intercourse? YES ☐ NO ☐
12. Sexually Transmitted Disease? *YES ☐ NO ☐

    * If yes, were you ever hospitalized or followed up? _____
13. Are you having any of the following symptoms that might be consistent with menopause? Please circle:

    Vaginal Dryness Hot Flashes Night Sweats Insomnia

    Irregular Periods Periods that have stopped for >6 months

    - Are these symptoms affecting your quality of life? _____
    - If you are already in menopause, how old were you when your periods stopped? _____
14. Infertility or difficulty getting pregnant? *YES ☐ NO ☐

    *If yes, please explain: _____
15. Are you planning to become pregnant in the next three months? YES ☐ NO ☐

SOCIAL:

Primary Language Spoke: _____

Significant Others Name: _____

Are you currently sexually active? YES ☐ NO ☐

How many times a week do you exercise? _____

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	Covid
Meningitis	Zostavax (Shingles)	Seasonal Flu	Gardasil	Other _____

OBSTETRICAL HISTORY:

Total Pregnancies: _____ Full-Term Pregnancies: ___ Premature: _____ Abortions: _____
Miscarriages: _____ Ectopic: _____ Multiple Births: _____
How many living children do you have? _____

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? _____

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

Date Started	Med/Vitamin/Supplement	Dose	Prescribed by:

Candler Hospital