SAVANNAH OB/GYN, PC

HEART & LUNG BLDG
5356 REYNOLDS ST., SUITE 410
SAVANNAH, GA 31405
(912) 355-8136 (912) 352-7014 Fax

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

Enclosed you will find our new patient information forms for you. Please forward the enclosed medical record release to your previous provider upon receiving this packet. Please complete all forms and bring with you, along with your insurance card, and identification 15 minutes prior to your appointment on _____ at _____. If you are having difficulties trying to obtaining your medical records please notify our office prior to your appointment.

We are asking that you give 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. 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.

Savannah OB/GYN, P.C.

NAME _____ DATE _____

AGE ____ HUSBAND NAME _____ AGE _____

RACE _____ RELIGION _____

CHIEF FEMALE COMPLAINT: _____

1. Duration of complaint – Days _____ Week _____ Months _____
2. Is complaint a recurring problem? _____

MENSTRUAL AND GYNECOLOGIC HISTORY:

Last normal menstrual period (date of onset, if known) _____

1. Menstrual Cycle Interval (example 28-30 days) _____
2. Menstrual Cycle length (example 5 days) _____
3. Number of pads or tampons used on heaviest day) _____
4. Bleeding or spotting between periods Yes _____ No _____
5. Vaginal Discharge Yes _____ No _____
   If yes a. Color: _____
   b. Odor Yes _____ No _____
   c. Worse Before _____ After_____ menstrual period
6. In last two years, have you missed more than three menstrual cycles at one time?
   Yes ____ No ____
7. Bleeding or spotting after sexual intercourse? Yes ____ No _____
8. Do you normally douche? Yes ____ No _____
   If yes a. How often do you douche? _____
   b. What material do you use? _____
9. Have you ever had female cancer? (i.e., of the breast or uterus) Yes ____ No ____
10. Have you ever been treated for vulvitis (itching around the vaginal opening?
    Yes ____ No ____
11. Have you ever been treated for venereal disease? Yes ___ No ___
12. Have you ever had an abnormal PAP smear? Yes ___ No ___

NAME _____

OBSTETRICAL HISTORY:

List pregnancies, if applicable

Year	Weight of Baby	Vaginal Delivery Or C-Section	Sex of Child	Child's Health

Complications with pregnancies? (i.e. high blood pressure, diabetes, etc?

_____

_____

FAMILY HISTORY:

1. Does your mother, or do your mother's sisters have female cancer, diabetes, or high blood pressure? Yes ____ No ____

2. Did your mother receive hormone treatment when pregnant with you? Yes ___ No ____

PERSONAL HISTORY:

1. Do you smoke? Yes ____ No ____
   a. How many years have you been smoking? _____ 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 _____
   If yes, which ones? _____
4. List any current medication which you are taking

   _____

   _____

   _____

PAST MEDICAL HISTORY

1. List operations

   _____

   _____

   _____

   _____

NAME _____

REVIEW OF SYSTEMS (Check yes if history of following problems)

HEENT	Headaches – frequent	Yes _____	No _____
	Glaucoma	Yes _____	No _____
	Allergies (sinus)	Yes _____	No _____
	Frequent Sore throat	Yes _____	No _____
NECK	Thyroid Disease	Yes _____	No _____
CHEST	Bronchitis – recurrent	Yes _____	No _____
	TB or Positive TB skin test	Yes _____	No _____
	Chronic Cough	Yes _____	No _____
	Blood in Sputum	Yes _____	No _____
	Shortness of Breath	Yes _____	No _____
CV	High Blood Pressure	Yes _____	No _____
	Chest Pain	Yes _____	No _____
	Shortness of Breath On Exertion	Yes _____	No _____
	Palpitations (heart races)	Yes _____	No _____
	Shortness of breath at night	Yes _____	No _____
BREAST	Breast Lumps	Yes _____	No _____
GI	Nausea	Yes _____	No _____
	Vomiting	Yes _____	No _____
	Diarrhea	Yes _____	No _____
	Constipation	Yes _____	No _____
	Hepatitis (yellow jaundice)	Yes _____	No _____
	Ulcers	Yes _____	No _____
	Vomiting Blood	Yes _____	No _____
	Gall Bladder disease	Yes _____	No _____
GU	Burning on urination	Yes _____	No _____
	Frequent urination	Yes _____	No _____
	(More than once every two hrs	Yes _____	No _____
	Urination at night	Yes _____	No _____
	Urgency of urination	Yes _____	No _____
	Blood in Urine	Yes _____	No _____
	History of kidney stones	Yes _____	No _____
	Do you leak urine when Coughing, sneezing or laughing	Yes _____	No _____
PSY	Psychiatric care or medication	Yes _____	No _____

NAME _____

NEURO	Seizures, epilepsy	Yes _____	No _____
EXT	Blood clots in legs	Yes _____	No _____
GEN	Diabetes (sugar)	Yes _____	No _____
	Anemia (low blood)	Yes _____	No _____

Today's Date _____

Patient Full Name as it appears on insurance card: _____

Date of Birth _____ SSN _____

Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Additional Phone _____ Email _____

Employer _____ Job/Dept _____

Spouse Full Name _____ Date of Birth _____

Spouse SSN _____ Phone # _____

Spouse Employer _____ Phone # _____

Emergency Contact (Friend/Relative) _____

Emergency Contact Primary Phone _____ Alternate _____

Primary Insurance _____ Insured Name _____

Insured SSN _____ Insured DOB _____ Relationship _____

Policy/ID # _____ Group# _____

Secondary Insurance _____ Insured Name _____

Insured SSN _____ Insured DOB _____ Relationship _____

Policy/ID # _____ Group# _____

If MINOR, Need Responsible Party's Name _____

Relationship _____ DOB _____ SSN _____

Responsible Party's Phone# _____ Alternate# _____

Referred by _____ Phone# _____

PLEASE PROVIDE INSURANCE CARDS AND DRIVER'S LICENSE TO BE COPIED.

EVERYTHING MUST BE COMPLETED IN FULL BEFORE BEING SEEN!!!!

LABORATORY CONSENT

For your convenience, we have "in house" laboratory services provided by GenPath. GenPath is considered In-Network with most insurance companies. Memorial Health (Coresource), United Healthcare, Aetna, Cigna, Anthem BCBS, BCBS GA (non PPO), Medicare, Medicaid and Tricare are some of the Network plans. For a complete list, see the receptionist. GenPath accepts and bills all insurance plans, even if they are not in-Network. With the exception of unmet copays and deductibles, patients are not held financially responsible for insurance denials and partial payments.

If you prefer we utilize another laboratory provider, you must notify us prior to any labs or test being done here on this form and in the lab area.

_____ I will use GenPath laboratory

_____ Preferred lab _____

Patient Signature _____ Date _____

WAIVER FOR PATIENT LIABILITY FOR NON-COVERED TEST AND SURGICAL PROCEDURES

Dear Patient:

There have been many changes to insurance coverage. Your Physician may order a test that your insurance doesn't cover. Our Physicians are committed to providing the very best health care and do not know if your insurance plan will cover all tests, such as Hemoglobin, Urinalysis, Hemocult (test blood in stool). Please understand that you will be responsible for tests and/or procedures not covered by your plan.

By signing I agree to be fully responsible if not covered by insurance.

Signature _____ Date _____

ADVANCED BENEFICIARY NOTICE FOR MEDICARE (ABN)

Medicare patient please initial below

_____ Medicare does not usually pay for a urinalysis without symptoms of a urinary problem.

_____ Medicare does not usually pay for hemoglobin without symptoms of anemia.

_____ Medicare only pays for a screening pelvic exam and pap every two years.

_____ Medicare does not cover finger stick cholesterol, the test must be a blood draw.

I have been notified by my Physician that he or she believes that, in my case, Medicare will likely deny payment for the service listed above. If Medicare denies payment I agree to be personally responsible.

Acknowledgement of receipt of Privacy Notice

I have been presented with a copy of Savannah OB/GYN PC's privacy policies detailing how my PHI may be used and disclosed as permitted under federal and state law. Your medical information will not be shared with even a family member. I understand the contents of the Notice and I request only the following individuals have access to my personal medical (including billing) information:

_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of previous and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignments of benefits apply.

Print patients name: _____ DOB _____

Signature: _____ Date _____

If not signed by patient, please indicate relationship to patient

Relationship: _____ Witnessed by: _____

Internal use only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By: (name and title) _____

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In order to save money on mail and save some trees from being made into pink and yellow cards, we are offering an email option. Please indicate below if we can contact you by email with lab results and other information:

_____ Yes please save the trees.

_____ No thank you, I prefer a card in the mail.

If you answered yes please put your full name and email address on the pink card.

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OBTAIN MEDICAL RECORDS

To: _____

_____

_____

_____

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 ST., SUITE 410
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 _____

Relation to Patient _____