

# 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.  
Leah Marks, RN MSN FNP  
Melanie L. Howard, RN MSN FNP

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

Melanie B. Helmken, 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/gynecological 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 10-15 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 INSURANCE 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 INSURANCE 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 <input type="checkbox"/> No <input type="checkbox"/>	Joint Pain/Injury	Yes <input type="checkbox"/> No <input type="checkbox"/>
Migraine Headache	Yes <input type="checkbox"/> No <input type="checkbox"/>	Breast Biopsy/Lumpectomy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cluster Headache	Yes <input type="checkbox"/> No <input type="checkbox"/>	Breast Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seasonal Allergies/Sinus Infection	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatoid Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lupus	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bronchitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Autoimmune Disorder (other)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pneumonia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Clotting Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>	Easy Bruising	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Clot (DVT or PE)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sickle Cell Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Attack	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Chicken Pox	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Cholesterol	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood Transfusion	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heartburn/GERD	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Gallbladder Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Endocrine Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chrohn’s or Ulcerative Colitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Constipation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Infectious Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diverticulitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Depression	Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bipolar Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney Stones	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anxiety	Yes <input type="checkbox"/> No <input type="checkbox"/>
Frequent UTIs (>3 per year)	Yes <input type="checkbox"/> No <input type="checkbox"/>	ADHD/ADD	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Substance Abuse/Alcoholism	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chronic Back Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Eating Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Irritable Bowel Syndrome	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>
Nausea	Yes <input type="checkbox"/> No <input type="checkbox"/>	Frequent Sore Throat	Yes <input type="checkbox"/> No <input type="checkbox"/>
Vomiting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Palpitations (heart races)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diarrhea	Yes <input type="checkbox"/> No <input type="checkbox"/>	Burning in Urination	Yes <input type="checkbox"/> No <input type="checkbox"/>
Vomiting Blood	Yes <input type="checkbox"/> No <input type="checkbox"/>	Frequent Urination	Yes <input type="checkbox"/> No <input type="checkbox"/>
Shortness of Breath	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood in Urine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chest Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Urgency/Leak of Urination	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

<u>Substance/Medication</u>	<u>Reaction</u>	<u>Date</u>

**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.)

<u>Date/Year</u>	<u>Surgery</u>	<u>Reason preformed/Diagnoses</u>	<u>Surgeon</u>

**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.

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

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 preform 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:

		<u>Date</u>	<u>Reason for test</u>	<u>Results</u>	<u>Physician</u>
DEXA (Bone Density) Scan	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____	_____	_____
Cholesterol (Lipid Panel)	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____	_____	_____
Colonoscopy	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____	_____	_____
Mammogram	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____	_____	_____
Pap Smear	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____	_____	_____
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	

**OBSTETRICAL HISTORY:**

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

**PREVIOUS PREGNANCIES:**

<u>Date</u>	<u>Weeks Gestation</u>	<u>Type of Delivery</u>	<u>Health of Child</u>	<u>Complications</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**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:

<u>Date Started</u>	<u>Med/Vitamin/Supplement</u>	<u>Dose</u>	<u>Prescribed by:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# 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 \_\_\_\_\_

## LABORATORY CONSENT

For your convenience, we have “in-house” laboratory services provided at both of our locations. These services are 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, please see the receptionist. The in-house laboratory services accept 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.

Please notify us prior to any labs or tests being done on this form or the lab area, which laboratory you prefer.

Please select one of the following:

- GenPath Laboratory (In-House for Dr. Smith & Dr. Burgett)
  
- LabCorp (In-House for Drs. Scarbrough, Odom, Jarrell, McIntosh, and Helmken)
  
- Quest Laboratory
  
- Candler Laboratory

Other: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



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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 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

\_\_\_\_\_  
Relation to Patient (if applicable)

# WAIVER FOR PATIENT LIABILITY FOR NON-COVERED TESTS AND SURGICAL PROCEDURES

Dear Patient:

There have been many changes to insurance coverage. Your physician may order a test that your insurance does not 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 urinalysis without symptoms of a urinary problem.

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

\_\_\_\_\_ Medicare only pays for a screening of 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.