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 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.

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

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 you benefits and understand that you are not 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, Zantac, 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 (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*

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 _________________________________