SAVANNAH OB/GYN, PC

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

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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/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 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

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 preformed/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 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:

		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	

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:

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

☐ LabCorp (In-House lab)

☐ Quest Laboratory

☐ Candler Laboratory

Other: _____

Patient Signature: _____ Date: _____/_____/_____

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Glen L. Scarbrough, M.D.

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)

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, Hemoccult (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.