PATIENT MEDICAL HISTORY

Please complete the following information as accurately as possible. If you cannot remember specific Details, please give best estimates. Your responses will help the provider address your medical concerns better.

Name:_____, DOB:_____Date:_____

Marital Status: Single___, Married___, Widowed___, Divorced___, Domestic Partner___ SS#_____

Address:_____, City_____, State____, Zip:_____

Home Phone:_____, Work Phone:_____, Cell Phone_____

Occupation:_____, Email:_____

Preferred Method of Communication: Phone_____, Mail_____, Email_____, Text_____

How did you hear about us?_____Referred by:_____

Spouse's Name:_____, Contact #_____,DOB_____

Spouse's
Occupation:_____

Emergency Contact Name:_____, Phone_____

Primary Care Physician_____, Phone_____, Fax_____

Pharmacy Name:_____, Phone_____, Location_____

Reason for Visit:
What is the reason for your visit: Annual_____, OB_____, Gyn Problem_____

What are your
symptoms:_____

Health Maintenance Screening Tests:

Colonoscopy: Yes____, No____, Results_____, Date_____
Dexa Scan : Yes____, No____, Results, _____, Date_____
Mammogram: Yes____, No____, Results, _____, Date_____

Pap Smear History:

Pap Smear: Yes_____, No_____, Results: Normal_____, Abnormal_____, Date:_____
LEEP: Yes_____, No:_____, Date_____
Colposcopy: Yes_____, No:_____, Date:_____
History of HPV: Yes____, No_____, Date:_____
Received HPV Vaccine: Yes:_____, Inj 1_____, Inj 2_____, Inj 3_____

Personal Medical History: Check if you had any of these medical problems in the past.

Major Illness	Yes	Major Illness	Yes
Anemia		Hepatitis ☐ A ☐ B ☐ C	
Anxiety		High blood Pressure	
Arthritis/Joint Pain		High Cholesterol	
Asthma		Hypothyroid	
Blood clot/DVT		Hyperthyroid	
Blood Transfusions		Interstitial Cystitis	
Breast Cancer		IBS (irritable bowel syndrome)	
Cancer- list type:		Jaundice	
Chronic Lung Disease		Migraines	
Depression		Osteopenia	
Diabetes Type1		Osteoporosis	
Diabetes Type 2		Ovarian Cancer	
Fibroids		Seizures	
Fracture		Sexually Transmitted Disease	
GERD		Stroke	
Heart Disease		Tuberculosis-TB	
Other:			

Past Surgical History: ☐ No past surgical history

Year	Surgery	Complications?

Current Medications: ☐ None If there is not sufficient space please attach copy of medications list to this form. Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs:

Medication	Dosage (mg)	Frequency	Prescribing Physician

Allergies: (Food, Drugs, Environmental) ☐None ☐Latex ☐Iodine

Allergy	Interaction	Allergy	Interaction

Family Medical History: Please indicate below significant medical problems of family members. Indicate which family member by checking the appropriate column and the AGE OF ONSET: ☐No Family History ☐Adopted

	None	Mother	Father	Brother	Sister	Grand Mother (Maternal)	Grand Mother (Paternal)	Grand Father (Maternal)	Grand Father (Paternal)	Aunt	Uncle
Blood Clots/DVT											
Breast Cancer											
Cervical Cancer											
Colon Cancer											
Diabetes											
Ovarian Cancer											
Hypertension											
Stroke											
Uterine Cancer											
Other Cancers not mentioned											
Other disease's not mentioned											

Genetic Screening: ☐ None Includes patient, baby's father, or anyone in either family

Indicate Yes or No	Yes	No		Yes	No
Tay-Sachs			Sickle Cell Disease or Trait		
Neural Tube Defect			Maternal Metabolic Disorder		
Other inherited Genetic or chromosomal Disorder			Mental Retardation/Autism		
Thalassemia			Medication/Street Drugs/Alcohol		
Hemophilia			Muscular Dystrophy		
Cystic Fibrosis			Huntington Chorea		
Down Syndrome			Congenital Heart defect		
Patient or father of the baby had/has a child with birth defects not listed			Recurrent pregnancy loss or a still birth		

Gynecology:

Age at first period:	1st day (date) of last period:
Frequency of period:	Describe Period: ☐Light ☐ Normal ☐ Heavy
Length of period:	Current Contraceptive Method:
Do you have concerns regarding your period? describe:	Are you in menopause? ☐Yes ☐ No ☐ Unsure Date of last period: Are you on hormone replacement therapy? ☐Yes ☐No

Obstetrics:

	Number		Number
Total number of pregnancies		Abortions Induced	
Full Term Births		Miscarriages	
Pre-Term Births		Living Children	

No.	Birth Date	#weeks at delivery	Sex	Birth Weight	Delivery Type	Complications	Location of Delivery
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

Social History

Are you currently sexually active? ☐ Yes ☐ No _____ If yes, what age did you become sexually active? _____

Current sexual partner (s) is/are: ☐ Male ☐ Female ☐ Male and Female_____

Have you had more than 5 sexual partners in a lifetime? ☐ Yes ☐ No If yes, how many?_____

Have you ever has any sexually transmitted diseases ?(STDs): ☐ Yes ☐ No

If yes, what kind? _____

Are you interested in STD screening? ☐ Yes ☐ No

Do you drink alcohol? ☐Yes ☐ No If yes, ☐ Social Drinker ☐ Daily if yes, how many drinks per week? _____

Do you use recreational drugs? ☐ Yes ☐ No If yes, what kind? _____

Do you use tobacco? ☐ Yes ☐ No If yes, Current every day _____ Current some days _____
Former_____ Never_____

If current, how many cigarettes a day?_____ _____if an occasional smoker – please describe:_____

Life Style: Please check off answer and give detail if it applies:

Have you been a victim of abuse or domestic violence? ☐ Yes ☐ No

Do you feel safe at home? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

Do you perform self -breast exam? ☐ Yes ☐ No

Do you drink milk or consume dairy products daily? ☐ Yes ☐ No

Do you take calcium tablets? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No If yes, frequency - how many times a week? _____

BLOOD TRANSFUION/PRODUCTS:	YES	NO	IF NO, PLEASE BRIEFLY EXPLAIN WHY.
WOULD YOU ACCEPT A BLOOD TRANSFUSION OR BLOOD PRODUCTS IN THE EVENT OF A LIFE THREATENING SITUATION?			

Please add any additional information:

AUTHORIZATION AND RELEASE:

I hereby certify that I have completed the above information to the best of my knowledge. I authorize, consent, request, and agree to actively participate in such services as routine assessments, the performance of diagnostic tests and procedures, care and treatment as self-referred or as ordered by my physician, his/her assistant or designees.

Signature **Date**

Please mail or fax your completed form to our office prior to your appointment. If you cannot return your form prior to your appointment, you must arrive 30 minutes early so we can enter your information into the computer. Thank you for your attention and cooperation.

Revised 4/2016

CONSENT TO TREAT AND OTHER ACKNOWLEDGMENTS

I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies). As ordered or approved by my provider, and I acknowledge and consent to the following: While routinely performed without incident, there may be a material risk associated with any procedure. If I have any questions concerning these procedures, I will as my provider to provide me with additional information. I also understand my provider may ask me to sign addition Informed Consent documents relating to specific procedures.

I authorize all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly North Atlanta OB-GYN, CPM OB-GYN and all professionals(including independent contractors) providing for such care and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to shall not be effective as Information released and/or charges incurred prior to such revocation.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits)

A copy of this document may be utilized the same as the original

Name:_____ DOB:____/____/____

Today's Date:____/____/____

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to you and your healthcare needs. Please understand payment of your bills is considered part of your care. The following is a statement of our financial policy. We require all of our patients to read and sign prior to treatment or consultation.

All patients must complete our information and provided insurance information before seeing the provider.
FULL PAYMENT IS DUE (UPON REQUEST) AT THE TIME OF SERVICE.
For your convenience, we accept Cash, Credit or Debit cards.

(Please initial after each number)

1. ____It is the responsibility of the patient to confirm that the provider is on their insurance plan and that your benefits are active. Our office will file claims to your insurance company for professional services rendered. We cannot bill your insurance carrier unless you give us your current insurance information. Please remember. **INSURANCE COVERAGE IS A LEGAL CONTRACT BETWEEN THE PATIENT AND THE INSURANCE COMPANY.**
2. ____If your insurance company has not paid your account in full at the end of **90 days**, the balance will be transferred to your responsibility for the payment in full.
3. ____All co-pays, co-insurances and deductibles are due at the time of treatment
4. ____If the patient cannot keep the scheduled appointment, it is the patient's responsibility to give our office at least **24 hours cancellation notice.** We reserve the right to charge an **$80** fee for missed or cancelled appointments. In-office procedures that are cancelled with less than 1 week notice will be subject to a **$300** non-refundable self pay service fee.
5. ____If you are turned over to collection agent, there will a **$50.00** processing/filing fee, as well as a fee of **40%** of your balance added to your account.

I HAVE READ AND ACCEPT THE ABOVE OFFICE FINANCIAL POLICY.

_____ DOB:____/____/____

Patient, Legal Guardian or Responsible Party Signature

Signature Date:_____/_____/_____

CPM
OB-GYN

Patient Consent & Acknowledge of Receipt of Privacy Notice

I, _____ understand that as part of the provision of healthcare services, CPM OB-GYN, creates and maintains health records describing my health information. This includes but is not limited to my health history, symptoms, diagnoses, examination and test results, and any plans for future treatment, personal information and insurance data.

I have read and/or have been provided with a copy of the Notice of Privacy Practices that provides a complete description of the uses and disclosures of certain health care information.

By signing this form, I consent to use and disclosure of the protected health information about me for the purpose of treatment, payment and healthcare operations. I understand that I have the right to revoke this consent in writing except where disclosures have already been made in reliance on my prior consent.

Patient printed Name:_____

Signature:_____ Date:____/____/____

Witness:_____ **Date:**____/____/____

I, hereby authorize and give permission to CPM OB-GYN to disclose and discuss any information related to my medical condition (s) to/with the following persons:

_____ _____
Name Relationship

_____ _____
Name Relationship

OR ___ Do not share my information with anyone outside of my PCP, Referring MD and Insurance Company.

I wish to be contacted in the following manner:

___Home/Work/Cell Number:_____ OR: ___Written Communication:
___OK To Leave a Detailed Message ___Ok to Mail to my Home Address
___Leave a Simple Message With A Call Back Number ___ Ok to Fax to this Number_____

By signing below, I authorize the release of any medical or other information deemed necessary by CPM OB-GYN including transferring of medical records to support medically necessary referrals to other health providers.

Signature of Patient:_____ **Date:**____/____/____

1628 Market Place Blvd
Cumming, Georgia 30041
Ph: 770-888-3102 Fax: 470-297-8032

5720 Buford Hwy Suite 102
Norcross, Georgia 300741
Ph: 770-729-1600 Fax: 770-729-1676

MEDICAL RECORDS RELEASE REQUEST

Patient Information:

Patient Name:_____, Contact Number_____

DOB:____/_____/_____ SS#_____

Home Address:_____

City, State and Zip:_____

I,_____authorize the above listed person/s, firm, or entity(or its agents, representatives or employee: to release for inspection and copying and use, any and all of the Personal health Information (PHI) listed below that pertains to my treatment, hospitalization or care from date/s of: _____/____/_____to_____/_____/_____

To/From:
CPM OB-GYN
1628 Market Place
Cumming, Georgia, 30071
Fax: 470-297-8032

To/From:
Name:_____
Address:_____
City, State, Zip:_____
Fax:_____

5720 Buford Hwy Suite 102
Norcross, Georgia 30041
FAX: 770-729-1676

Note: **All** records will be reviewed by the provider prior to being released. This may take up to 72 hours. Please note, a fee of $25 will be required if the records are released **to you**

What Records Do You Need:

- ☐ Entire Record
- ☐ Radiology/X ray Reports
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Laboratory Results
- ☐ Labor & Delivery Records
- ☐ ER/Hospital Reports
- ☐ Other:_____

Reason For Records Request: Recolation_____,Insurance Change_____, Patient Discontent_____ Second Opinion_____ Employment Request_____Other_____

Patient Signature Of Release:_____ Date___/____/____