SOUTHWEST GEORGIA
OBSTETRICS | GYNECOLOGY
Celebrating Women's Health

NEW PATIENT INFORMATION SHEET

Name: _____ Age: _____ Date of birth: _____

Social Security #: _____ Marital Status [ ] S [ ] M [ ] D [ ] W

Race:

[ ] African American/Black [ ] Asian [ ] Native [ ] American Indian/Alaska Native [ ] Caucasian/White [ ] Other [ ] Unknown [ ] Declined

Hawaiian/Pacific Islander

Ethnicity:

[ ] Hispanic/Latino [ ] Non- Hispanic/Latino [ ] Unknown [ ] Declined

Address: _____ City: _____

State: _____ Zip code: _____ Pharmacy: _____

E-mail: _____

Employer: _____ Occupation: _____

Home phone: _____ Cell phone: _____ Work Phone: _____

Spouse's Name: _____ DOB: _____ Employer: _____

INSURANCE (Please give insurance card to receptionist)

Insured's Name: _____ Relation to Patient: _____ DOB: _____

Insured's Employer (if other than patient) _____ Employer Phone # _____

Insurance ID: _____ Group # _____

Consent for treatment: I consent to necessary treatment, including drugs, medicine, performance of operations, or other studies that may be used by the attending physician; his/her nurse or staff.

Authorization for release of information: I authorize the release of any and all treatment and service information to third parties to facilitate billing, collection or referrals for services to other providers. This includes psychological or psychiatric care, attention and treatment.

Non-covered routine services and collection policy: As your physician, I want to provide you with the best care possible. There may be certain routine services that I feel necessary for the maintenance of your good health that are not covered by your health insurance contract. We would appreciate your cooperation in paying for these services in a timely manner. This may include but not limited to lab procedures, pathology services, injections, diagnostic tests (i.e. ultrasound) or in-office surgical procedures. These may not be covered by your contract. Let me assure you that I only order tests I feel are necessary for your good health.

In accepting assignment, the doctor has agreed that the amount allowed by your insurance becomes the total charge for any service. However, patients are responsible for any amount applied to the deductible and the co-insurance amount.

I understand that SWGA OB/GYN cannot accept or file the following insurances: Medicare and Medicaid.

By signing below you accept the responsibility for any costs not covered by your insurance. Also any collection costs, including but not limited to reasonable attorney's fees and court costs.

Private Pay: I understand that an initial payment will be due at the time of service. I also understand that I am responsible for any additional charges that may incur from my visit(s).

I have read your policy and agree to be held responsible for the services.

I have been offered a copy of the Notice of Privacy Practices as adopted by Southwest Georgia OB/GYN.

Signature: _____ Date: _____

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PATIENT HISTORY FORM

Name: _____ Date: _____ DOB: _____

Reason for visit: _____ Who were you referred by: _____

ALLERGIES: _____

PAST MEDICAL HISTORY: (Circle all that apply)

Adverse Reaction to Anesthesia
Allergies
Alzheimer's
Asthma
Bleeding/Clotting Disorder*
Breast Disease
Cancer*
Diabetes
Emphysema
Epilepsy/Seizures
Heart Disease
Hypertension (High Blood Pressure)
Inherited/Autoimmune disease*
Kidney Disease
Liver Disease
Mental Disorder
Migraine
Osteoporosis
Phlebitis (Blood Clots in veins)
Pneumonia
Rheumatic Fever
Sexually transmitted infections
(gonorrhea, chlamydia, syphilis, herpes,
genital warts/HPV)
Stroke/TIA
Thyroid Disorder/Disease
Tuberculosis(TB)

*Specify here: _____

Other: _____

FAMILY HISTORY: (Parents, brother, sister, Children or maternal/paternal grandparents)

Breast Cancer	[ ]Yes	[ ]No	Who?_____
Ovarian Cancer	[ ]Yes	[ ]No	Who?_____
Cancer	[ ]Yes	[ ]No	Who?_____
Diabetes	[ ]Yes	[ ]No	Who?_____
Heart Disease	[ ]Yes	[ ]No	Who?_____
High Blood Pressure	[ ]Yes	[ ]No	Who?_____
Increased cholesterol	[ ]Yes	[ ]No	Who?_____
Stroke	[ ]Yes	[ ]No	Who?_____

Other _____

Primary Care Physician: _____

Do you use:

Alcohol: [ ]No [ ] Social only [ ]Daily

Tobacco: [ ]No [ ]Yes, how much? _____

Other drugs: [ ]No [ ]Yes, which ones? _____

PAST SURGERIES: (Please list all surgical procedures)

Date:	Procedure:	Hospital:

GYNECOLOGIC HISTORY:

Age of 1st period? _____ Days between first day of one period and first day of next period? _____ (days)

What is the length of your period? _____ (days) Your periods are: [ ]Heavy [ ]Moderate [ ]Light

When was the first day of your last period? _____

What is your current method of birth control? _____

Do you have bleeding between periods? [ ]Yes [ ]No

Have you ever had an abnormal pap? ? [ ]Yes [ ]No

Date of last pap smear: _____ Date of last mammogram: _____

Date of last Dexa Scan: _____ Date of last colonoscopy: _____

MEDICATIONS: (list dosage, taken daily or as needed)
Please list all medications including: birth control, vitamins, and all over-the-counter medicines.

Medication	Dosage	Taken Daily or Taken As Needed	

PAST OBSTETRICAL HISTORY
List all pregnancies (including term pregnancies, preterm pregnancies, still births, miscarriages, abortions, tubal pregnancies) date, type of dellivery and any complications:

Date of Birth	Sex	Birth Weight	Type of Delivery	Place of delivery	Complications

Pregnancy Plans (If pregnant, please answer the following)

Are you interested in taking childbirth class, childbirth refresher course or parenting class? [ ]Yes [ ]No

Do you plan to: [ ]Bottle Feed [ ]Breast Feed [ ]Unsure Have you selected a pediatrician? [ ]Yes [ ]No

EMERGENCY CONTACT INFORMATION:

Name _____ Relationship _____ Phone # _____