NEW PATIENT INFORMATION SHEET

Name: ____ Age: ________ Date of birth: _____________________

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

Race:

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

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 provide a copy of insurance card with paperwork)

Insured's Name: _______________________________ Relation to Patient: _____________________ DOB: _______________

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

Insurance ID: _________________________ Group # _________________________ Carrier: ___________________________

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.

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: __________________________________

PATIENT HISTORY FORM

Name: ________________________________ Date: __________________________ DOB: ____________________

Reason for visit: _______________________________________ How did you hear about us: _____________________

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 # ____________________