WOMEN'S HEALTH
OF AUGUSTA
Obstetrics & Gynecology

# WELCOME TO OUR PRACTICE

Please complete the enclosed forms for your medical records. When you arrive for your appointment, present these forms, your insurance card, and a picture ID to our front desk teammember.

At the time of each visit, you will need to present your insurance card and picture ID. If you are currently on any medications, please bring a list of those medications to inform your care provider.

We look forward to meeting you and providing you with professional and quality medical care.

706.733.4427 | 1303 D'Antignac Street, Suite 2500 | Augusta, Georgia 30901

womenshealthofaugusta.com

# PATIENT INFORMATION SHEET

Date: _____ Physician you are seeing: _____

Referred by: _____ Name you prefer to be called: _____

Patient's Last Name: _____ First: _____ Middle: _____

Birthdate: _____ Social Security #: _____ Race: _____ Religion: _____

Address, City, State, Zip: _____

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

Marital Status: _____ Email Address _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired

Employed by: _____ Occupation: _____

Emergency Contact: _____ Phone Number: _____

Relationship to Patient: _____

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*Insurance Policy Holder is the person who holds the insurance policy on the patient.*

Insurance Company Name: _____

Name of Policy Holder: _____ Relationship to Patient _____

Policy Holder's DOB: _____ Policy Holder's Social Security #: _____

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**Insurance Benefits:** Women's Health of Augusta, PC wants to help you receive your maximum insurance benefits. In order to do this, you need to know if your policy has annual preventative/routine coverage. We code and bill for services according to your medical record documentation. We cannot comply with any request to improperly alter coding of your office visit procedures. Improperly altering coding and billing information is considered Healthcare Fraud.

**All co-payments, co-insurance and deductible amounts must be paid at time of service.** If you do not have insurance or we do not participate with your insurance plan, payment is expected in full at time of service. I understand and will abide by the payment policy above and will also be responsible for any additional charges submitted to a radiological or laboratory facility.

**Insurance payment order:** I hereby authorize and direct you to pay directly to Women's Health of Augusta, PC benefits due me out of indemnity under the terms of my policy issued by your company. Payment is authorized upon your receipt of an itemized statement for services rendered to me. This policy was in full force and effect at the time that these services are rendered. Payment of this amount is hereby directed in whole or in part, shall be considered the same as if paid by your company directly to me.

**Medical records authorization release:** I hereby authorize Women's Health of Augusta, PC to disclose, when requested to do so by insurance carrier(s) or its representatives for application to obtain insurance or to pay a claim, and all information with respect to illness, injury, medical history, consultation, prescription or treatment, included copies of all medical records.

**Consent Form:** I hereby authorize the physicians of Women's Health of Augusta, PC to perform/administer the following treatment: Medical and/or surgical procedures, performance of diagnostic procedures, tests and cultures, administration of anesthetics, use of prescribed medications as deemed necessary and authorize release of information needed to secure payment. This consent will remain in effect until revoked in writing.

Legal Signature: _____ Date: _____

# NEW PATIENT QUESTIONNAIRE

Name: _____ Date: _____ Account: _____

Birthdate: _____ Age: _____ Occupation: _____

***DIRECTIONS:*** *Please circle, check ( ✓ ) or fill in the blanks with the answers best describing your situation. All information will be held confidential and used to provide proper care.*

Reason for seeing doctor: _____

## OBSTETRICAL AND GYNECOLOGIC HISTORY

1. How old were you when you first started your period? _____
2. Do you have pain with your period? ☐ YES ☐ NO
   *If yes,* when do you have pain? (Before, During, After) _____
   *If yes,* how long does the pain last? _____
3. Do you have swelling before your periods? ☐ YES ☐ NO
4. DATE OF THE FIRST DAY OF YOUR LAST MENSTRUAL PERIOD:
5. How many days pass between the first day of each period? _____ days pass
6. How long do your periods last? _____ days
7. On your heaviest day, how many pads and/or tampons do you use? _____ pads and/or _____ tampons at most
   _____ soaked _____ mild _____ moderate
   How many pads at one time? _____ pads at one time
   How many days are heavy? _____ days
8. Are you sexually active? ☐ YES ☐ NO If YES, Partner is ☐ MALE ☐ FEMALE ☐ BOTH
9. Do you have pain with intercourse? ☐ YES ☐ NO
10. Do you have bleeding with intercourse? ☐ YES ☐ NO
11. Do you bleed between periods? ☐ YES ☐ NO
12. When was your last pap smear? _____
13. Have you ever had an abnormal pap smear? ☐ YES ☐ NO
    *If yes,* What treatment was done? _____
14. Contraception (pills, condoms, etc.) _____
15. Tubal Ligation? ☐ YES ☐ NO
16. Vasectomy? ☐ YES ☐ NO
17. Last Mammogram _____

## PREGNANCY HISTORY

____ # of Pregnancies ____ # of Miscarriages ____ # of Abortions ____ # of Living Children

| | BORN MONTH/YEAR | HOSPITAL CITY/STATE | HOURS IN LABOR | SEX | WEIGHT | TYPE OF DELIVERY | COMPLICATIONS |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |

## MEDICAL HISTORY

1. Please list any type of surgery you have had and the year of the surgery. _____

2. Please list any other hospitalization you have had and the reason (not including childbirth): _____

3. Did you have any childhood diseases? ☐ YES ☐ NO If yes, please list: _____

*(continued on reverse)*

## MEDICAL HISTORY

4. Last Colonoscopy _____
5. Age 65 and older: Pneumovax Immunization ☐ YES ☐ NO If yes, when: _____
   Date of last tetanus shot: _____
6. Please list any medications you are now taking, the dosages, and reason for medication. Include over the counter medications.

_____

_____

7. Are you allergic to any medications, latex or iodine? ☐ YES ☐ NO If yes, please list & describe how you react to them:

_____

8. Have you ever had any injuries (i.e. broken bones, concussions)? ☐ YES ☐ NO If yes, please list: _____

_____

_____

9. Have you ever had a blood transfusion? ☐ YES ☐ NO If yes, when: _____
10. Do you have or have you ever had any problems with any of the following? Check ( ✓ ) appropriate line and explain positive finding below.

| | | |
|---|---|---|
| ☐ Eyes, Ears, Nose and Throat | ☐ Bowel Problems | ☐ Phlebitis |
| ☐ Thyroid Disease | ☐ Kidney Disease | ☐ Blood Clots in Legs or Lungs |
| ☐ Diabetes | ☐ Urinary Tract Infections | ☐ Genital Herpes |
| ☐ Breast | ☐ Mental Disorders | ☐ Gonorrhea |
| ☐ Asthma, Bronchitis, Pneumonia | ☐ Seizure Disorders | ☐ Syphilis |
| ☐ Heart Disease or Murmur | ☐ Migraine Headaches | ☐ Condyloma (Warts) |
| ☐ Heart Attack | ☐ Anxiety Disorder, Depression | ☐ Chlamydia |
| ☐ High Cholesterol | ☐ Blood Disorder, Easy Bruising | ☐ AIDS or HIV Exposure |
| ☐ High Blood Pressure | ☐ Anemia | ☐ Trichomonas |
| ☐ Stroke | ☐ Hemophilia | ☐ DES Exposure - Did your mother take it? |
| ☐ Liver Disease, Hepatitis | ☐ Arthritis | ☐ Cancer (Specify) |
| ☐ Stomach Problems | ☐ Varicosities | ☐ Other |

DETAIL POSITIVE FINDINGS: _____

_____

_____

Primary Care Physician (Family Practitioner or Internist): _____
Last Exam: _____
Other Specialists you see: _____

## FAMILY HISTORY

Are you adopted? ☐ YES ☐ NO
If any family member has had any of the problems indicated above (SEE QUESTION #10), please list problem(s) on appropriate line.

| | *Problems* | *If Deceased, Cause of Death* | *Age of Death* |
|---|---|---|---|
| Father: | | | |
| Mother: | | | |
| Brothers: | | | |
| Sisters: | | | |
| Grandparents: | | | |
| Other: | | | |

## HEALTH HISTORY

1. Number of caffeine drinks per day (coffee, tea, soda): _____
2. Number of alcoholic drinks per day (beer, wine, liquor): _____
   Do you feel you have a drinking problem? ☐ YES ☐ NO
3. Smoking: Never ☐ Quit (when) _____ Yes (number per day) _____ How many years? _____
4. Street drugs (cocaine, marijuana, others) ☐ YES ☐ NO If yes, what and how often? _____
   Do you feel you have a street drug or prescription pain drug problem? _____
5. Calcium servings (milk, cheese, yogurt, etc.) or supplements (mg.) per day: _____
6. Do you perform monthly breast self exams? ☐ YES ☐ NO
7. What do you do for exercise? _____ Frequency per week and duration: _____
8. Do you have sex related concerns? _____
9. Have you ever been sexually or emotionally abused? ☐ YES ☐ NO
10. Are you interested in HIV (AIDS), Syphilis or other sexually transmitted disease testing? ☐ YES ☐ NO If yes, which one: _____
11. Do you feel you need treatment for anxiety/depression? ☐ YES ☐ NO

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please print information. All information must be completed in entirety prior to releasing/obtaining records.

Patient's Name _____ DOB _____
Last First M/I

Address _____

City _____ State _____ Zip _____

Please check the appropriate authorization request:

**Entire Medical Record**

or

**Treatment date(s) From _____ to _____(only records from these dates will be released)**

( ) Release my records to: ( ) Obtain my records from:

Name of Entity _____

Attn: _____ Phone Number: _____

Address _____

City _____ State _____ Zip _____

Description of information to be released:
( ) All records for above dates ( ) Pregnancy records ( ) Bone Density report(s) ( ) Mammogram report(s) ( ) Pap Smear report(s)
( ) Other (specify) _____

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I understand that these medical records may or may not contain information pertaining to psychiatric counseling or testing, alcohol or drug abuse counseling or testing, and/or HIV/ARC testing, I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) and/or entity(ies) as stated above. This authorization/consent will remain in effect for a period of one (1) year from the date stated below, unless revoked in writing by the person to which it pertains (or his/her parent, legal guardian or legally authorized agent), to the Medical Records Department. These medical records are being disclosed under the provisions of the applicable New Jersey State and Federal Law.

NOTICE TO THE RECEPIENT OF RECORDS: The information has been disclosed to you from records protected by Federal Laws of confidentiality (42 C.F.R. Part 2). These laws prohibit you from making any further disclosure of these records, unless further disclosure is expressly permitted by written authorization by the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of these medical records is not sufficient for this purpose. You may only use these medical records for the purpose(s) as stated above.

_____ _____
Signature of Patient or Date
Personal Representative (as defined by HIPAA, attach personal representative authority form)

Office use only: Receiving employee: _____ Date Received: _____

# FINANCIAL POLICIES

Thank you for choosing Women's Health of Augusta for your healthcare needs. We are committed to providing you with the best possible care. Our physicians and staff value you as a patient and hope to establish a relationship based on understanding and excellent communication. Our financial policy is a necessary part of our treatment program. We have outlined the most common financial/insurance issues for your convenience. If you need further information, please ask to speak with our Billing and Insurance office.

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**INSURANCE:** You must provide your insurance card each visit at check in. Your medical insurance coverage is a contract between you and your insurance company. If you are not sure whether or not your insurance will pay for a particular service, you should check with your insurance company prior to having the service performed. If you have out-of-network insurance, you will be responsible for filing your own claim, and will be required to pay in full at the time of service. Your insurance company requires us to collect co-pays, coinsurance, and deductible amounts. If you do not have insurance, payment in full is expected at the time of service. We accept cash, checks, debit cards and all major credit cards.

**LAB SERVICES:** If your insurance company requires your lab work to go to a specific lab, it is your responsibility to inform our staff. If you do not tell us where to send your lab work, it will be sent to our contracted lab.

**BILLING:** We file your insurance for you as a courtesy. Anything not covered by your insurance is your responsibility. You will receive a bill from us for any balance unpaid by your insurance company. The balance is due upon receipt of the bill. If you need to set up payment arrangements, it is very important that you call promptly to arrange this. Balances are considered past due 30 days after you receive your first bill. If you have not paid your account after 90 days, we reserve the right to cancel any appointments you have scheduled and we may obtain the services of an outside collection agency to collect your balance. In this case, any fees we incur in this process will be added to your balance and will become your responsibility.

**Missed Appointments:** Women's Health of Augusta reserves the right to charge a fee of $25.00 for missed appointments that you have not provided notification to our office 24 hours in advance. Multiple missed appointments may lead to dismissal of a patient from our practice, upon the physician's discretion.

**FORMS/PAPERWORK:** Forms and paperwork, including but not limited to disability and FMLA, will be filled out for you for a fee of $10. Payment is due at the time of the request. Paperwork is completed as time permits and you will be notified when it is complete.

**RETURNED CHECKS:** If your check is returned for any reason, we will charge the account an additional $30, per returned check.

Patients with accounts having a history of nonpayment are subject to being dismissed from this practice.

**MINORS:** All services rendered to minor patients will be the financial responsibility of the adult accompanying the minor.

I have read and understand the financial policy of the practice and I agree to be bound by its terms.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Please Print the Name of the Patient Date of Birth

*(January 2021)*