East Georgia Women's Center

Patient Information:

Last Name_____First Name_____

Date of Birth_____ Phone #_____

Alternative Phone #_____ Marital Status (circle one) S M D W

Social Security #_____-_____-_____ Race_____

Mailing Address_____APT/UNIT #_____

City_____ State_____Zip Code_____

Email Address _____

PHARMACY_____City of Pharmacy_____

Employer/Occupation _____

Spouse Information:

Name_____ Phone #_____

History:

1st DAY of LAST Period Month_____ Day_____ Year_____

List of MEDICATIONS/New ALLERGIES

_____

_____

_____

_____

Any NEW Surgeries:_____

RELEASE OF INFORMATION:

List any person(s) who we may release your medical information to is they call our office.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Emergency Contact(s)

Name:_____ Phone #_____

Name:_____ Phone #_____

Patient Signature:_____ **Date**_____

East Georgia Women's Center

Managed Care mandates that you use in-network physicians, labs, hospitals and services in order to receive in-network payment. In order to help you stay compliant with your insurance requirements:

- It is the patient's responsibility to provide all necessary information to bill their insurance(s). A copy of your insurance card will be made at your initial visit to our facility to assure we have the most recent information. If you do not present your insurance card at the time of service, your appointment or procedure will be rescheduled.
- Please note that if your primary insurance has a co-pay or deductible requirement , this will be collected prior to seeing the provider. If payment is not made at time of service, your appointment or procedure will be rescheduled.
- For patients with high deductible plans, a deposit of $250 will be expected at time of Pre-op or procedure will be rescheduled.
- If you arrive 15 minutes late for your appointment, the appointment will be rescheduled.
- For patients who do not show for a procedure or do not cancel 2 days prior to their scheduled procedure time a $50.00 fee will be charged.
- It is the patient's responsibility to verify in or out of network benefits with their insurance company.
- In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay the charges.
- It is understood that returned checks made payable to this office for insufficient funds, stop payments, or other reasons for non-payment will be assessed a $25.00 service charge for which I agree to be held responsible.
- In the event that your account is placed with a collection agency we ask that you pay half of your balance accumulated before your next visit at this office.

Pathology/Lab services are performed by LabCorp.

It is the patient's responsibility to verify if the above providers are in-network with the insurance provided by the patient. Patient will be responsible if services are out-of-network.

I have read the information and understand that **I am responsible** for notification of my insurance plan mandates.

Patient Signature _____ **Date**_____

East Georgia Women's Center *Welcome to our office!*

Name:_____ DOB:_____ Date:_____

PATIENT'S PERSONAL HISTORY

** When filling out this form be as detailed as possible, the more information you can provide for us the better we can meet your healthcare needs.*

What is the reason for your visit today?_____

What do you currently use for birth control? Please circle all that apply.

Pills Condoms Nuvaring IUD Depo Provera Tubal Ligation Abstinence Vasectomy

What was the first day of your last menstrual period?_____

Is your period usually light, moderate, or heavy. (circle)

What age did menstruation begin? _____How many days does your period last?_____

If you have begun menopause at what age did it start?_____

Medications List: (If you need additional space please ask front desk for medication list form)

Check if None: ☐

* Please include name of birth control pills, if taking.

Name of Medicine:	Strength:	How many times per day?	Prescribing Doctor:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medications? If yes list them as well as the reaction that you have to the medicine. Check if None: ☐

_____, _____, _____

Are you allergic to Latex or Iodine? Circle all that apply. Check if None: ☐

Health Maintenance

When was your ....

Last Pap: _____ Last Bone Density: _____

Last Mammogram: _____ Last Cholesterol: _____

Last Colonoscopy: _____

Do you have any of these medical conditions? Circle all that apply.

Anemia Asthma Diabetes Thyroid Problems Depression/ Anxiety Gallbladder Problems Heart Problems

High Blood Pressure Kidney Problems Sickle Cell Disease/ Sickle Cell Trait Other:_____

Name:_____ DOB:_____ Date:_____

Past Surgeries

Have you ever had an operation? Circle those that apply to you.

* Please include those surgeries you had done even as a child.

Surgery	Date	Surgeon
Check if none of these: □		
Laparoscopy		
Hysterectomy		
D & C		
Gallbladder		
Ovarian cyst removal		
Tubal pregnancy		
Tubal Ligation		
Appendix removed		
Tonsils removed		
C-Section		
Wisdom teeth removed		
Other		

OB History:

How many times have you been pregnant? _____ How many living children do you have? _____

Have you had twins, triplets, or more in the past? Circle all that apply.

How many of the following have you had: Ectopic Pregnancies:_____ Abortions:_____

Full Term Births: _____ Premature Births: _____ Miscarriages:_____

GYN History

Have you ever had any of the following problems? Circle all that apply.

Abnormal Pap Cancer Painful Menstruation Endometriosis

Fibroids Infertility Ovarian Cyst Pelvic Inflammatory Disease Urinary Leakage

Have you ever had?	Write Yes or No	Date	Treated?
Chlamydia			
Gonorrhea			
Herpes			
Syphilis			
HIV			

Name:_____ DOB:_____ Date:_____

Social History:

Primary Language: _____ Marital Status: _____

Employer: _____ Occupation: _____

Spouses Name: _____ Spouse's Occupation: _____

Circle all that apply: Smoking: past present never If you currently smoke, how many packs per day? _____

If you smoked in the past, how long did you smoke? _____ When did you quit? _____

Alcohol Use: occasional regular never

Drug Use (ex. cocaine, marijuana, meth.): past present never What type of drug(s) did you use? _____

How often did you use these drugs?_____ How long did the drug use last? _____

Are you currently sexually active? Circle one. Yes or No

(Circle One) Exercise: some none regular

What kind of diet are you on? Regular Low fat Diabetic Low Salt Other_____

Family History:

Has anyone in your family ever had any of the following: Circle all that apply.

Condition	Father	Mother	Sister	Brother	Grandmother	Grandfather
Anemia	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	☐	☐

Other:_____

Self or Family Cancer Assessment

Circle all that apply.

Do you or does anyone in your immediate family have a history of....

Breast Cancer:	Self	Mother	Sister		
Ovarian Cancer:	Self	Mother	Sister		
Colon Caner:	Self	Mother	Sister	Father	Brother