PATIENT REGISTRATION

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:_____

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner ☐

Address:_____ City:_____ State:____ Zip:_____

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

Email: _____

Occupation:_____

Spouse's Name:_____ Contact #_____

Spouse's Occupation:_____

Emergency Contact Name:_____ Phone #:_____

Primary Care Physician: _____

Phone: _____ Fax: _____

Pharmacy: _____ Address: _____ Phone #: _____

Reason for Visit:

What is the reason for your visit: Annual _____ OB _____ Gyn Problem _____

What are your symptoms:_____

I authorize CPM OBGYN to send me SMS messages to confirm my next appointment.

Signature:_____Date:_____ Time:_____(am/pm)

Medical History ☐None

Check all that apply to you:

MAJOR ILLNESS	YES	MAJOR ILLNESS	YES
Anemia		Hepatitis ☐ A ☐ B ☐C	
Anxiety		High Blood Pressure	
Arthritis/ Joint pain		High Cholesterol	
Asthma		Hypothyroidism	
Blood cloth/DVT		Hyperthyroid	
Blood transfusions		Interstitial Cystitis	
Breast Cancer		IBS (Irritable bowel movement)	
Cancer (List type):		Jaundice	
Chronic Lung Disease		Migraines	
Depression		Neurologic/Epilepsy	
Diabetes type 1		Osteopenia	
Diabetes type 2		Osteoporosis	
Endometriosis		Ovarian Cancer	
Fibroids		Seizures	
Fracture		Sexually Transmitted Disease	
GERD		Stroke	
Heart Disease		Tuberculosis - TB	

Other: _____

Allergies ☐None

Please include any food or drug allergy.

Allergy	Reaction

Gynecological History

Check all that apply to you:

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 ☐ No ☐
Inj 1☐ Inj 2☐ Inj 3☐

Mammogram: Yes ☐ No ☐ Results: _____ Date: _____

Date of last period (1st day): _____ **Age at first period: _____**
Length of period: _____ **Frequency of period: _____**
Current contraceptive method: _____ **Describe period: Light ☐ Normal ☐ Heavy ☐**
Are you currently in hormone replacement therapy: Yes ☐ No ☐
Are you in menopause: Yes ☐ No ☐

Past Surgical History: None ☐

Year	Surgery	Complications

Current Medications: None ☐

Medication	Dosage (mg)	Frequency	Prescribing Physician

Obstetrics History

Total # of pregnancies		Abortions Induced	
Full term births		Miscarriages	
Preterm births		Living Children	

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

Genetic Screening: None ☐

Includes the patient, the 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 disorder			Mental Retardation/ Autism		
Thalassemia			Medication/Street Drugs/Alcohol		
Hemophilia			Muscular Dystrophy		
Cystic Fibrosis			Huntington Chorea		
Down Syndrome			Congenital Heart Disease		
Patient or father of the baby had/has a child with birth defects not listed.			Recurrent pregnancy loss or a still birth		

Family Medical History ☐ No family history ☐ Adopted

Please indicate below significant medical problems of family members. Indicate which family member by checking the appropriate column.

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

Pharmacy

Pharmacy name: _____
Address: _____
Phone number: _____

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

Have you ever had 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 everyday ☐ Current some days ☐ Former ☐ Never

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

Life Style

Please check off answers and give details if it applies.

Have you ever 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 exams? ☐ 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? _____

AUTHORIZATION TO RECEIVE BLOOD TRANSFUSION / PRODUCTS

Although pregnancy and childbirth are very natural events, at times they can be complicated by problems which require the use of blood or blood products to be used. Refusal to accept a blood transfusion under these circumstances can endanger the life of the mother or baby and can lead to death, disability or prolonged recuperation. These problems are rare and occur in less than one hundred (1:100) pregnancies. There are infrequent, not serious risks from blood transfusions which may include infections such as Hepatitis, HIV or Transfusion reactions.

I authorize the transfusion of blood products to me, when deemed necessary by my physician, anesthesiologist, or their associates and assistants. I will give the physician at CPM OB-GYN a 30 day notice in writing if I wish to revoke this authorization.

_____ _____

Signature Date

_____ _____

Witness Date

AUTORIZACIÓN PARA RECIBIR TRANSFUSIÓN SANGUÍNEA

A pesar de qué el embarazo y el parto son eventos naturales, en algunas ocasiones pueden presentarse complicaciones que requieren el uso de sangre o derivados sanguíneos. Estas complicaciones pueden poner en peligro la vida de la madre o del bebé, o bien provocar enfermedades, causar una recuperación prolongada e incluso la muerte. Dichas complicaciones son raras y ocurren en menos de uno en cien (1:100) embarazos. Existen riesgos serios qué no se presentan de manera frecuente, como lo son Hepatitis C, VIH o reacciones negativas a la transfusión.

Yo autorizo la transfusión de sangre y/o derivados sanguíneos en caso de qué el personal médico lo considere necesario. Así mismo daré notificación, con 30 días de anticipación al personal médico de Clínica CPM OB-GYN en caso de revocar está autorización.

_____ _____

Firma Fecha

_____ _____

Testigo Fecha

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 ask my provider to provide me with additional information. I also understand my provider may ask me to sign additional 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 payers 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)

Signature: _____ Today's date: ____/_____/_____.

Opt in to receive text messages for lab results.

Phone Number: _____

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 provide 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 a $80 fee for missed or canceled appointments. In-office procedures that are canceled 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 a collection agent, there will be 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.

_____

Patient, Legal Guardian or Responsible Party Signature

Signature Date:_____/____/_____

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 disclose 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:
___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:**____/_____/____

HEALTH INSURANCE VERIFICATION

Patient Information:

Patient Name: _____
Date of Birth: _____
Address: _____
Phone: _____ Email: _____

Patient Insurance Information:

Insurance provider:

☐ Aetna
☐ Ambetter of PeachState **(CORE)**
☐ Blue Cross Blue Shield
☐ Cigna
☐ Medicaid
☐ Amerigroup
☐ Caresource
☐ Peach State
☐ United Healthcare
☐ Oscar

Other: _____

Member ID: _____ Group Number: _____
Subscriber Name: _____ Date of Birth: _____
Subscriber's Relationship to Patient: _____

Insurance Verification:

Is the insurance coverage active? ☐ Yes ☐ No
Begin Date: _____ End Date: _____
Type of Insurance Plan: ☐ HMO ☐ PPO ☐ Medicaid ☐ Medicare ☐ Other: _____
Referral Requirements for Specialist Visits: ☐ Required ☐ Not Required

Date Verified: _____ Verified by: _____

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

5720 Buford Hwy Suite 102
Norcross, Georgia 30071
Ph: 770-888-3102 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

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

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

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: Relocation___ Insurance Change___ Patient Discontent___
Second Opinion___ Employment Request____Other_____

Patient Signature Of Release:_____ Date___/____/____