

NAME: _____ MR # _____

D.O.B. _____



THIS INFORMATION IS IMPORTANT AND CONFIDENTIAL. PLEASE BE FRANK. ANSWER THE QUESTIONS AS BEST YOU CAN. IF YOU NEED ASSISTANCE, ASK YOUR NURSE OR DOCTOR.

Patient's Name _____ S/S # _____
(last) (first) (middle)

Address _____
(street) (city) (state) (zip)

Birth Date _____ Age _____ Sex _____ Race _____ Status: M ___ S ___ D ___ Sep ___ W ___

Occupation _____ Where Employed _____

Home Phone () _____ Business Phone () _____ Ext: _____

Person to Contact in Emergency (Other than Family Member) _____

Relationship _____ Phone _____

PAST MEDICAL HISTORY

(1) Past and Present Illnesses/Hospitalizations/Surgeries:

Illness	Year	Illness	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(2) Medications currently taking (prescription and non-prescription)

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(3) Allergic or bad reaction to medication

_____	_____	_____	_____
-------	-------	-------	-------

FAMILY HISTORY

(4) Family Diseases:

Disease	Family Member	Disease	Family Member
<input type="checkbox"/> Heart Attack	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Ovarian, Uterine, Cervical Cancer	_____
<input type="checkbox"/> Breast Cancer	_____	<input type="checkbox"/> Other Cancers	_____
<input type="checkbox"/> Stroke	_____		
<input type="checkbox"/> Thyroid	_____		

SOCIAL HISTORY

(5) Smoking:

- Currently smoke? Packs per day: _____ Total years smoking: _____
- Stopped Smoking? How long ago: _____ Total years smoking: _____
- Never smoked.

(6) Exercise:

- Regularly exercise? Type: _____ How often: _____

(7) Weekly alcohol consumption: Beer: _____ Wine: _____ Hard liquor: _____

(8) Drugs used regularly:

- Marijuana Barbituates Amphetamines Opiates Cocaine

(9) Weight a year ago: _____ Present weight: _____

MEDICAL SYSTEM REVIEW

1. Venereal Diseases:

- | | |
|------------------------------------|-------|
| | Year |
| <input type="checkbox"/> Gonorrhea | _____ |
| <input type="checkbox"/> Herpes | _____ |
| <input type="checkbox"/> Syphilis | _____ |
| <input type="checkbox"/> Chlamydia | _____ |

2. Urinary problems

- Kidney stones
- Bladder or kidney infection
- Painful or burning urination
- Too frequent urination
- Urine loss
- Blood in urine

3. Blood Disorders

- Low blood count (anemia)
- Easy bruising
- Sickle cell disease
- Bleeding problems with surgery or injury
- Family members with bleeding problems
- Other: _____

4. Lungs

- Asthma
- Other

5. Heart

- MVP
- Murmur
- Other

6. Stomach and Intestinal Problems

- Constipation
- Vomiting Blood
- Indigestion
- Diarrhea
- Bloody or black bowel movement
- Other: _____

7. Liver Problems:

- Hepatitis
- Gall bladder trouble
- Jaundice
- Other: _____

8. Menstrual History

- Age period started: _____
- Age period stopped: _____
- Age period stopped naturally: _____
- Age at time of hysterectomy: _____
- Problems with your periods
- Excessive bleeding
 - Excessive cramping or pain
 - Bleeding between periods
 - Bleeding with or after intercourse
 - Vaginal discharge

11. Date of last pap smear: _____

12. Date of last mammogram, if ever: _____

Who may we thank for this referral?

9. Method of Birth Control

- Birth control pill
- Diaphragm
- Bilateral tubal ligation
- Intrauterine device
- Condom
- Vasectomy
- Vaginal foam or jelly
- Rhythm
- Not satisfied with method
- Other: _____

10. Pregnancy History:

- Total number of pregnancies: _____
- Number of miscarriages: _____
- Number of abortions: _____
- Living children: _____
- Pregnancy Problems
- Excessive weight gain
 - Vaginal bleeding
 - High blood pressure
 - Problems with delivery
 - Toxemia



Penn Marc Centre • 6401 Poplar Avenue, Suite 530 • Memphis, TN 38119
Telephone (901) 767-9368

OFFICE POLICY ON MANAGED CARE INSURERS

OB/GYN Specialists, P.C. has enrolled in numerous managed care insurance programs to accommodate the needs of our patients.

With each insurance program, there are many individual requirements of the plans having different stipulations regarding what services are covered and how often they may be performed.

Unfortunately, if you do not inform us of special requirements in your insurance contract such as lab work, preventative care, hospitalization, and/or out-patient procedures that are not covered or must go to a specific location, or the need for a referral from your primary care physician, we have no choice but to bill you directly for those charges. Payments for those charges are then your responsibility.

Please check with your insurance provider if you have any questions relating to the services that we provide. We want you to receive all of the benefits offered to you.

I have read and understand the office policy stated above and agree to accept responsibility as described.

SIGNATURE

DATE

Yvonne F. Moore, M.D., FACOG • Paula Pilgrim, M.D., FACOG
Susan Lacy, M.D., FACOG • Jessica Ruffin, M.D. • Leslie Mayo, M.D.



Result Notification Release

Patient _____

It is important that we are able to contact you regarding test results or other aspects of your care. Please complete the following information:

1. Cell Phone # _____
(Unless otherwise indicated, we will leave messages on your cell phone voice mail.)

Comments _____

2. Home # _____

May we leave a message for you to call us on your home answering machine? _____ Yes _____ No N/A

May we leave a message for you to call us with a family member? _____ Yes _____ No N/A

Please specify name/s of family member _____

May we discuss test results with a family member. _____ Yes _____ No N/A

Please specify name/s of family member _____

3. Work # _____ ext _____

May we call you at work? _____ Yes _____ No N/A

May we leave a message on your work voice mail? _____ Yes _____ No N/A

There are numerous Walgreens, Walmarts, & Rite-Aids. To ensure that we call your medications to the correct pharmacy, please give us that name and number. _____

Are there any special instructions we should know about? _____

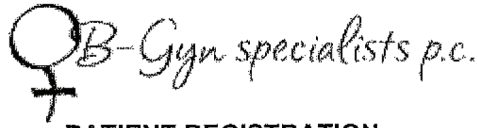
Patient Signature

Date

I authorize the doctors of OB/GYN Specialists, P.C. to fax/send lab/test results to any physician I am referred to for consultation. Only results that would be pertinent to my consultation are to be sent.

Patient Signature

Date



**PATIENT REGISTRATION
PLEASE COMPLETE ALL BLANKS**

PLEASE PRINT

PATIENT							
NAME	LAST	FIRST	M.I.	AGE	DATE OF BIRTH	RACE	ARE YOU PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No
ADDRESS			CITY		STATE	ZIP	
SOCIAL SECURITY NUMBER	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced		HAVE YOU BEEN TREATED BY THESE PHYSICIANS BEFORE? <input type="checkbox"/> Yes <input type="checkbox"/> No		CELL PHONE	HOME PHONE	
EMAIL ADDRESS			OCCUPATION		NAME OF EMPLOYER		
EMPLOYER'S ADDRESS				CITY	STATE	ZIP	PHONE
IN CASE OF EMERGENCY CONTACT:	NAME	ADDRESS				PHONE	

SPOUSE/PARENT				
SPOUSE/PARENT	ADDRESS		DATE OF BIRTH	PHONE
SOCIAL SECURITY NUMBER	OCCUPATION	NAME OF EMPLOYER		

INSURANCE					
INSURANCE COMPANY NAME	MAIL CLAIMS TO: STREET	CITY	STATE	ZIP	PHONE
POLICY HOLDER (IF GROUP, EMPLOYER)	RESPONSIBLE PARTY:	POLICY OR ID #	GROUP OR ACCOUNT #		
INSURANCE COMPANY NAME	MAIL CLAIMS TO: STREET	CITY	STATE	ZIP	PHONE
POLICY HOLDER (IF GROUP, EMPLOYER)	RESPONSIBLE PARTY:	POLICY OR ID #	GROUP OR ACCOUNT #		

PLEASE READ AND SIGN

ASSIGNMENT AND RELEASE: I hereby authorize OB/GYN Specialists, P.C. to furnish information to insurance carriers concerning treatment, and hereby assign to the doctor all insurance benefits otherwise payable to me for these services. I understand that I am financially responsible for all charges not covered by my insurance. I also understand that I am responsible for reasonable collection costs and/or attorney fees incurred for the collection of this account. I agree to follow all office policies set by OB/GYN Specialists, P.C. I agree to provide any information requested by OB/GYN Specialists, P.C. concerning my account. I understand and agree to fill out the requested forms and updates when requested by OB/GYN Specialists, P.C. without delay and I understand that if I do not provide updates, forms and new insurance information I will be responsible for all charges to my account. I also understand that the information provided by me will be provided to an OB/GYN Specialists, P.C. outside collection agency should my account become past due by 90 days or 3 billing cycles for collection procedures.

PLEASE NOTE: There will be a \$25.00 charge for returned checks. Twenty-four (24) hour notice is required for cancellation of appointment. Failure to give 24 hour notice may result in a \$25.00 fee. There will be a \$25 resubmission fee if you request that we refile your insurance.

Responsible Party Signature: _____

Print Name: _____

Date: _____

Reviewed by Staff Member: _____

This form will remain in effect for 1 year from the date signed or until any information on this form/account changes at which time I agree to fill out a new form with the correct information without delay. I also agree to provide new insurance cards within 2 weeks of receiving them. I understand that if I delay in providing new insurance information my claims may be denied for timely filing limit and that I will be solely responsible for the affected charges. Initials: _____

OB/GYN Specialists, P.C.

Notice of Privacy Practices for Protected Health Information

Summary and Signature Page

I hereby acknowledge that I have been provided a Privacy Notice for OB/GYN Specialists, P.C. and understand my rights as a patient.

I understand that my protected health information (PHI) can be used for treatment, payment and health care operations.

I understand that I have certain rights to restrict the use and disclosure of my PHI, to obtain a copy of the Notice of Privacy Practices for protected Health Information, to amend in order to correct incomplete or incorrect information in my records, to receive an accounting of disclosures of my PHI, and to request that communication of my PHI be made by alternative means or at an alternative location.

I understand that I can request additional information by contacting Kathy Graves (767-9368).

I understand that I can file a complaint by contacting Jeanne Distretti and that I may also file a complaint by contacting the Secretary of Health and Human Services at 200 Independence Avenue SW, Room 615F, Washington, D.C. 20201.

I understand that I may be contacted by your office for appointment reminders, alternative treatment information, and with information about other health-related benefits and services.

Unless I object, my PHI may be disclosed to assist in notifying a family member, and/or certain other individuals responsible for my care about my location, general condition or my death. My PHI may also be disclosed to assist in disaster relief efforts.

I understand that my PHI may be disclosed as mandated and without my authorization in the following instances:

Controlling Disease	Research
Child Abuse and Neglect	Threat to Health and Safety
Abuse, Neglect, or Domestic Violence	Specialized Governmental Functions
Judicial/Administrative Procedures	Workers Compensation

I understand that my PHI may be disclosed as mandated and without my authorization to the following agencies/individuals:

Food and Drug Administration (FDA)	Organ Procurement Organizations
Oversight Agencies	Correctional Institutions
Law Enforcement	
Coroners, Medical Examiners, Funeral Directors	

I understand that other uses of my PHI will be made only as otherwise authorized by law or with my written authorization which I may revoke except to the extent information or actions have already been taken.

Signature

Date