



Welcome to Medical Centers OB/GYN

Please complete the attached new patient paperwork. After your paperwork is completely filled out please mail or bring this packet back to our office. Once we receive your paperwork someone will call you within 2 to 3 business days to schedule an appointment.

If you have any questions, please call our office at 256-840-3396 during normal business hours, Monday through Thursday 8:00am-4:30pm and Friday 8:00am-12:00pm, we are closed for lunch from 12:00pm-1:00pm.

Thank you,

Medical Centers OB/GYN staff

\*\*\*\*\*Please bring your insurance card and driver's license to your appointment, along with your copay. Copays are due at the time of service. \*\*\*\*\*

**2505 US Hwy 431  
Women's Center Suite B  
Boaz, AL 35957  
256-840-3396  
Fax 256- 840-3394**



PATIENT INFORMATION:

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_ SSN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Residential Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (Primary): (\_\_\_\_) \_\_\_\_\_ Telephone (Secondary): (\_\_\_\_) \_\_\_\_\_

Race: (Please circle) Caucasian African American Native American Alaskan Asian Native Hawaiian

Pacific Islander Other: \_\_\_\_\_ Declined

Primary Language: English Spanish Other: \_\_\_\_\_

Marital Status: (Please Circle) Single Married Divorced Widowed Separated

Student: (Please Circle) Full-Time Part-Time Not a student

Employment: (Please Circle) Full-Time Part-Time Not Employed Self Employed Retired

(If Employed) Employer: \_\_\_\_\_

Telephone (Work): (\_\_\_\_) \_\_\_\_\_ Occupation: \_\_\_\_\_

Pharmacy: (Please list name and location; Ex: Wal-Mart- Arab) \_\_\_\_\_

Who were you referred by: \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION: (If under 18)

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone (Primary): (\_\_\_\_) \_\_\_\_\_ Telephone (Secondary): (\_\_\_\_) \_\_\_\_\_

Telephone (work): (\_\_\_\_) \_\_\_\_\_

EMERGENCY CONTACT:

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone (Primary): (\_\_\_\_) \_\_\_\_\_ Telephone (Secondary): (\_\_\_\_) \_\_\_\_\_

Telephone (work): (\_\_\_\_) \_\_\_\_\_

MEDICAL INSURANCE INFORMATION:

**Primary Coverage**

Insurance Company Name: \_\_\_\_\_

Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Telephone (work): ( \_\_\_\_\_ ) \_\_\_\_\_

**Secondary Coverage**

Insurance Company Name: \_\_\_\_\_

Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Telephone (work): ( \_\_\_\_\_ ) \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Follow My Health

<https://medicalcentersobgyn.followmyhealth.com>

With Follow My Health, you can:

- Review your medical records online in a safe, secure environment
- Communicate privately with physicians via secure messaging
- Get appointment reminders
- View test and lab results
- Request Rx refills
- And more!

It is available online 24 hours a day, 7 days a week via any computer, tablet or smart phone!

Please check a box below:

**YES! I wish to participate!**

Please Provide:

- Patient's Full Name: \_\_\_\_\_
- Patient's Date of Birth: \_\_\_\_\_
- Guardian (s) Name: \_\_\_\_\_
- Relationship to Patient: \_\_\_\_\_
- E-Mail Address: \_\_\_\_\_

**No I do not wish to participate.** (No additional information is required)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



\_\_\_\_\_  
Patient Name

**AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT**

I, \_\_\_\_\_, hereby authorize the Medical Centers OB/GYN, the physicians in charge of the care of the above listed patient to administer any treatment as may be deemed necessary or advisable in the diagnosis and treatment of the patient.

**Assignment of Insurance Benefits:** I hereby authorize payment directly to the Medical Centers OB/GYN and to any physician(s) who have provided any medical services for benefits payable under the terms of my policy(s) for this period of care.

**Guaranty Agreement:** For and in consideration of services rendered and/or to be rendered by the Medical Centers OB/GYN and any physician(s) treating me therein, I/we hereby agree to pay and guarantee payment to the clinic and physician(s). We each severally agree to pay all costs of collecting or securing, or attempting to collect or secure, this note, including a reasonable attorney's fee.

**Medicare Insurance Assignment Statement to Permit Payment of Medical Insurance Benefits to the Clinic and Physician(s):** I hereby certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in the Medical Centers OB/GYN including physician's services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

**Medicaid Insurance Assignment Patient's Certification, Authorization to Release Information, and Payment Request:** I authorize any holder of medical or other information about me to release any information needed for this or any related Medicaid claim to the Medicaid fiscal intermediary, the Medical Services Administration, and/or to any other parties who may be liable for any of my Medicaid expenses.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**Privacy Policy:** Would you like a copy of the privacy policy? It is stating we cannot share your information without your permission. (If you list anyone on the next page we can release information to them).

I have requested a copy\_\_\_\_\_

I have declined a copy\_\_\_\_\_



**OFFICE POLICIES**

Please **initial** after reading each Policy

*Initial in the boxes below*

If you arrive 15 minutes after your scheduled appointment time you will be asked to reschedule, unless prior arrangements with our office has been made.	
After 3 no-show appointments for established patients or 2 no-show appointments for New Patients, patients face the possibility of termination from the Practice. Please call to cancel or reschedule an appointment if you have a conflict.	
All copays are due at the time of your office visit.	
In the event that you establish care with a different OB/GYN physician you will no longer be allowed to schedule an appointment with our office.	
Please request school or work excuses for the day of your appointment before you leave the office.	
All types of medical forms and medical records requests require a minimum of 7 – 10 business days to process.	
All normal results for labs and imaging will be available through Follow My Health Patient Portal.	
Pregnancy deductible and co-insurance payments are due no later than the 20th week of pregnancy.	
Picture Identification and insurance card(s) must be brought with you to all scheduled appointments.	
When calling to speak to a nurse, please choose your nurse’s option on the phone tree. Please allow 24 hours for the nurse to return your phone call. To schedule an appointment, please choose option 1.	
If you need a prescription refilled please contact your pharmacy to get them to send a refill request.	

**Thank you for complying with our office policies. We appreciate our patients!**

**PRIVACY CONFIDENTIALITY ACT AUTHORIZATION FOR CONTACT AND MESSAGES**

DUE TO THE PRIVACY CONFIDENTIALITY ACT, please list the people that you approve to have access to your information as stated below: Medical Records Information: (test results, prescription information, appointment information...etc.)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



I, \_\_\_\_\_, authorize Medical Centers OB/GYN to obtain records on my behalf from the following sources:

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These records are to include:

- Clinical date
- Laboratory
- Radiology
- History and Physical
- Consultations
- Progress Notes
- Pathology Reports
- Discharge Summary
- Physician Orders
- Other (Specify) \_\_\_\_\_

Date upon which this consent becomes null and void: \_\_\_\_\_.

By my signature below I agree that I have voluntarily signed this consent without threat or coercive measures. I understand that by law this information cannot be forwarded to anyone else without my express written permission. This authorization hereby releases the sender from all legal responsibility or liability from the release of the information described from my patient records. I understand that I may revoke this consent to receive records at any time, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this document will be null and void after 60 days.

**Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

Witness: \_\_\_\_\_

If patient cannot sign, document reason and signature or proxy:

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PROHIBITION OF REDISCLOSURE: if the information disclosed contains data related to alcohol and/or drug abuse, psychiatric or psychosocial impairment, the information has been disclosed from records whose confidentiality is protected by federal law (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 cfr part 2. 4/8/08

**HEALTH HISTORY**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

**Past Medical History**

Do you have now or have you ever had the following? (Circle "yes" or "no".)

AIDS or HIV+	yes	no	High Blood Pressure	yes	no
Anxiety	yes	no	High Cholesterol	yes	no
Arthritis	yes	no	Kidney Disease	yes	no
Bleeding Disorders	yes	no	Migraine headaches	yes	no
Blood transfusions	yes	no	Mitral Valve Prolapse	yes	no
Cancer	yes	no	Rheumatic Fever	yes	no
Deep Vein Thrombosis	yes	no	Seasonal allergies	yes	no
Depression	yes	no	Seizures	yes	no
Diabetes	yes	no	Stroke	yes	no
Emphysema	yes	no	Thyroid Disease	yes	no
Glaucoma	yes	no	Tuberculosis	yes	no
Heart Disease	yes	no	Polio	yes	no
Hepatitis	yes	no	Ulcers	yes	no

Other medical condition(s) not listed: \_\_\_\_\_

Age Period began: \_\_\_\_\_

Age at Menopause: \_\_\_\_\_

First day of your last menstrual period: \_\_\_\_\_

Are your periods: (Please circle)      Regular    Irregular

Are your periods: (Please circle)      Scant      Light      Moderate      Heavy

Have you ever had any of the following sexually transmitted diseases? (Please circle)

Chlamydia    Genital warts    Gonorrhea    Herpes    HPV    Syphilis    Trichomoniasis    None



**Surgical History: (Please list any past surgeries or hospitalizations including the dates)**

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**Obstetric History: (List all pregnancies, dates, and outcomes)**

Date	Sex	Weight	Any Complications?
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

**Health Maintenance: (When was your last?)**

Date (Month/Year)	Normal	Abnormal
Pap smear _____	_____	_____
Mammogram _____	_____	_____
Colonoscopy _____	_____	_____
Bone Density Scan (Dexa) _____	_____	_____

**Social: (Please circle)**

Do you smoke? Yes No If yes, how many packs per day? \_\_\_\_\_

Do you drink alcohol? Yes No If yes, how much? Occasional Moderate Heavy

Do you use illegal drugs? Yes No If yes, what type and how often? \_\_\_\_\_

Do you drink caffeine? Yes No If yes, how many servings per day? \_\_\_\_\_

Are you currently sexually active? Yes No Have you ever been sexually active? Yes No

Method of contraception (Please circle)

Tubal sterilization Vasectomy Pills Depo-Provera IUD Implant Condoms Natural family planning

NuvaRing None Other \_\_\_\_\_

Do you currently exercise? Yes No If yes, how often? \_\_\_\_\_

Have you ever been a victim of domestic/sexual abuse? Yes No If yes, when?

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**Family History:**

Do you have a family history of any of the following: **(Specify maternal or paternal)**

Breast Cancer	Yes	No	_____
Colon Cancer	Yes	No	_____
DVT/PE's (Blood Clots)	Yes	No	_____
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
Hypertension	Yes	No	_____
Ovarian Cancer	Yes	No	_____
Uterine Cancer	Yes	No	_____

**Medications:**

Drug Name	Dosage	Frequency
_____		
_____		
_____		
_____		
_____		
_____		
_____		
_____		

**Supplements:**

Drug Name	Dosage	Frequency
_____		
_____		
_____		

**Allergies:**

\_\_\_\_\_  
\_\_\_\_\_

**Immunizations:**

Are your immunizations up to date?      \_\_\_\_\_ Yes      \_\_\_\_\_ No  
Gardasil (HPV) immunization?      \_\_\_\_\_ Yes      \_\_\_\_\_ No  
When was your last flu shot? (Month/Year) \_\_\_\_\_

**Review of Systems:**

Are you currently having any of these symptoms?

**General**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Chills
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Fever
<input type="checkbox"/>	<input type="checkbox"/>	Recent weight gain
<input type="checkbox"/>	<input type="checkbox"/>	Recent weight loss

**Skin**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Dry skin
<input type="checkbox"/>	<input type="checkbox"/>	New or growing moles
<input type="checkbox"/>	<input type="checkbox"/>	Pigmented lesions

**Breast**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Breast lump
<input type="checkbox"/>	<input type="checkbox"/>	Breast pain
<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge
<input type="checkbox"/>	<input type="checkbox"/>	Skin changes

**Cardiovascular**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing while walking
<input type="checkbox"/>	<input type="checkbox"/>	Edema
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations

**Gastrointestinal**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Bloody stool
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Incontinence of stool
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting

**Genitourinary**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal or painful periods
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal vaginal bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal vaginal discharge
<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Change in frequency
<input type="checkbox"/>	<input type="checkbox"/>	Incomplete emptying
<input type="checkbox"/>	<input type="checkbox"/>	Leaking urine when coughing/sneezing
<input type="checkbox"/>	<input type="checkbox"/>	Pain with sex
<input type="checkbox"/>	<input type="checkbox"/>	Pain with urination
<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Urgency

**Musculoskeletal**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	<input type="checkbox"/>	Muscle/joint pain

**Neurological**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Lightheadedness
<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Severe memory problems
<input type="checkbox"/>	<input type="checkbox"/>	Trouble walking

**Psychiatric**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Mood changes

**Endocrine**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Hair loss
<input type="checkbox"/>	<input type="checkbox"/>	Heat/cold intolerance
<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid
<input type="checkbox"/>	<input type="checkbox"/>	Libido changes