MEDICAL CENTERS OB/GYN

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_____

MEDICAL CENTERS OB/GYN

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:

_____

_____

_____

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:

_____

_____

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

MEDICAL CENTERS OB/GYN
2505 US Hwy 431, Women's Center Suite B, Boaz, AL 35957
Office 256-840-3396 Fax 256-840-3394

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)

_____

_____

_____

_____

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?

_____

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	
( )	( )	Chills
( )	( )	Fatigue
( )	( )	Fever
( )	( )	Recent weight gain
( )	( )	Recent weight loss

Skin

Yes	No	
( )	( )	Dry skin
( )	( )	New or growing moles
( )	( )	Pigmented lesions

Breast

Yes	No	
( )	( )	Breast lump
( )	( )	Breast pain
( )	( )	Nipple discharge
( )	( )	Skin changes

Cardiovascular

Yes	No	
( )	( )	Chest pain
( )	( )	Difficulty breathing while walking
( )	( )	Edema
( )	( )	Palpitations

Gastrointestinal

Yes	No	
( )	( )	Bloody stool
( )	( )	Constipation
( )	( )	Diarrhea
( )	( )	Incontinence of stool
( )	( )	Indigestion
( )	( )	Nausea
( )	( )	Pain
( )	( )	Vomiting

Genitourinary

Yes	No	
( )	( )	Abnormal or painful periods
( )	( )	Abnormal vaginal bleeding
( )	( )	Abnormal vaginal discharge
( )	( )	Blood in urine
( )	( )	Change in frequency
( )	( )	Incomplete emptying
( )	( )	Leaking urine when coughing/sneezing
( )	( )	Pain with sex
( )	( )	Pain with urination
( )	( )	PMS
( )	( )	Urgency

Musculoskeletal

Yes	No	
( )	( )	Muscle weakness
( )	( )	Muscle/joint pain

Neurological

Yes	No	
( )	( )	Dizziness/Lightheadedness
( )	( )	Headache
( )	( )	Numbness
( )	( )	Seizures
( )	( )	Severe memory problems
( )	( )	Trouble walking

Psychiatric

Yes	No	
( )	( )	Anxiety
( )	( )	Depression
( )	( )	Mood changes

Endocrine

Yes	No	
( )	( )	Diabetes
( )	( )	Hair loss
( )	( )	Heat/cold intolerance
( )	( )	Hot flashes
( )	( )	Hypothyroid
( )	( )	Libido changes