MATERNAL GYNERATIONS

600 Professional Dr., Suite 200, Lawrenceville, GA 30046
2098 Teron Trace, Suite 150, Dacula, GA 30019
Call 770.513.4000 | Fax 770.237.2523
MaternalGynerations.net

PATIENT ACCOUNT # _____ Referred by: _____

Preferred Pharmacy, Address, Phone Number & City_____
By providing a pharmacy, I give permission to send and receive prescription information between Maternal Gynerations, PC and my pharmacy

Your Name: _____
Last First Middle
Preferred Name: _____ Primary Language: _____

Date of Birth: _____ SSN: _____

Race: □ American Ind. /Alaska Native □ Asian □ Black/African American □ Nat Hawaiian/Pacific Islander □ White □ Other Race □ Decline
Ethnicity: (MUST COMPLETE) □ Hispanic or Latino □ Not Hispanic or Latino □ Declined Marital Status: S M D W

Address: _____Apt # _____

City: _____ State: _____ Zip Code: _____

Home # _____Work# _____Cell # _____

Email: _____ Employer: _____

Preferred Communication for Appointment Reminders: □ Email □ Phone □ Text

Emergency Contact: _____Relationship: _____ Phone Number: _____

Is your insurance through (please circle all that apply): My Employer Private Spouse Parent

Insurance Co. Name: _____

Full Name of Insured: _____

Date of Birth: _____Social Security Number: _____

It is the policy of this office to pay for services in full when rendered except in cases of pregnancy or surgery. If this applies to you, we will file your claim and you will be expected to pay only what the insurance does not pay. You must have your current insurance card at time of service or you will be expected to pay in full. Return check fee is $30. A no show fee of $25-50 will be billed if appointment is not cancelled within 24 hours. Insurance is not a guarantee of payment. It is your responsibility to confirm your benefits.

In case any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein incurred. If this account is placed with a collection agency, the undersigned parties agree to pay all fees for cost of collections.

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information for the processing of this claim. I understand that my prescription will be sent, and my medication information, including formulary benefits, may be obtained through MatGyn electronic prescribing function.

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____

HIPAA PRIVACY RULE: Please list the parties that you authorize Maternal Gynerations, P.C. to disclose your protected health information (PHI). **MUST BE FILLED OUT BY PATIENT ONLY** (If this form is completed electronically via the Patient Portal, then you will be asked to initial this HIPPA Authorization when you come in to the office.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

DO YOU GIVE MATERNAL GYNERATIONS P.C. PERMISSION TO LEAVE VOICEMAILS REGARDING TEST RESULTS? □ Yes □ No
PATIENT'S INITIALS _____

I HAVE RECEIVED/READ A COPY OF MATERNAL GYNERATIONS. P.C. NOTICE OF PRIVACY PRACTICES. PATIENT'S INITIALS _____

Maternal Gynerations - Annual

Name	Birthdate	Age
Preferred Name		
What are some questions you would like answered today?		
Any changes in your health history since your last visit?		
Are you taking any new medications?		

Your GYN History

First day of your last menstral period:	
How many days are there from the start of one period to the start of your next period?	
How long does your period last? _____days.	Flow: □ Light □ Medium □ Heavy Clots □ Yes □ No
How often do you change pads/tampons?	
Do you have cramps with your period? □No □Yes: □ Mild □ Moderate □ Severe	
Do you have pelvic pain at other times? □ No □ Yes If yes when:	
Do you have bleeding between periods? □ No □ Yes If yes when:	
What are you using to prevent pregnancy?	
Are you planning to have another child? □ No □ Yes If yes when:	

Your Social History

History of Abuse □ No □ Physical □ Emotional □ Sexual Did you receive counseling? □ Yes □ No	
Do you do self breast exams □ Yes □ No	
Do you exercise? □ No □ Yes _____ days a week	
Do you smoke? □ No □ Yes How much?	
How many alcoholic drinks do you have in a week?	
Any other drug use? □ No □ Yes How much?	What types and how often?
Do you drink milk or eat dairy products? □ No □ Yes Servings per day _____	
Do you take calcium? □ No □ Yes How much?	
Marital Status: □ Single □ Married □ Widowed □ Divorced □ Seperated □ Engaged	
Do you have sex with: □ Men □ Women □ Both	
Do you currently have a sexual partner? □ No □ Yes How long?	
Do you use seat belts □ Yes □ No	

Review of Systems

Please circle if any of the following apply to you NOW.

Constitutional:	Fatigue Fever Hot flashes Weight Loss Weight Gain
HENT:	Headaches Lightheadedness Nose Bleeds Sinus Pain Thyroid Mass Sore Throat
BREAST:	Lumps Tenderness Swelling Nipple Discharge
CARDIOVASCULAR:	Chest pain Irregular Heart Rate Rapid Heartbeat Fainting Swelling of legs Varicose Veins
GASTROINTESTINAL:	Nausea Vomiting Diarrhea Constipation Abdominal Pain Blood in stools
GENITOURINARY:	Urgency Frequency Painful urination Nighttime urination Blood in urine Leaking urine
	Decreased sex drive Painful intercourse Genital Sores
SKIN:	Rash Itching Dry skin New lesions or moles Acne
ENDOCRINE:	Loss of Hair Cold intolerance Heat intolerance
PSYCHIATRIC:	Anxiety Depression Compulsive Behavior Impulsive Behavior
	Suicide thoughts Excess anger Mood swings
HEMOTOLOGICAL/ LYMPHATIC:	Easy bruising Lymph node enlargement