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 ________

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LAB BILLING POLICY

Please read carefully and sign at the bottom. A copy will be provided to you upon request.

Unless you request differently, all lab work will be sent to Quest Diagnostics. If your insurance company requires it to be sent elsewhere, please let us know before any lab work is collected. Our office bills for the physician's office visit portion, but you will receive a separate bill directly from the lab for their processing of any specimens. Specimens obtained can include tissue, swab, or urine specimens, cultures, biopsies, pap smears, blood work, etc.

As a courtesy to the patient, any insurance information that you have provided prior to collection of the specimen will be given to the lab so that they can submit it for processing. However, this bill will remain the patient's responsibility. If no insurance information is given, then 100% of the lab charge will be billed directly to the patient by the lab.

If you have any questions, please ask our office personnel for clarification.

I have read and understand the above policy and agree to abide by its terms.

______________________________ ______________________
Patient Signature Date

______________________________ ______________________
Print Name Date of Birth

____
Acct. #

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PAIN MEDICINE POLICY

Please read carefully and sign at the bottom. A copy will be provided to you upon request.

1. I agree to take narcotic medication exactly as instructed. I am NOT allowed to change dosage amounts or alter the time schedule of taking the medication without first talking to my prescribing physician.
2. Narcotics will NOT be phoned in after business hours or on weekends.
3. Only one pharmacy will be used for filling narcotic prescriptions.
4. The following are conditions for immediate termination from the practice.
   a. Obtaining narcotics from any other physician while under our care without our knowledge.
   b. Altering or forging of a prescription is a felony and will be reported.
5. Patients may be terminated from the practice with 30 days' notice for noncompliance in the taking of their medication.
6. We will NOT refill prescriptions that have been lost or misplaced. Please be responsible in keeping up with your narcotic prescriptions.
7. Stolen medications will be replaced ONE time only if you have a valid police report.
8. In the case of intolerance or ineffective narcotic medications, a different prescription could be given, provided the unused portion of the previously prescribed medication was returned.
9. I am aware that most of the manufacturers of drugs used to treat chronic pain recommend AGAINST the operation of heavy equipment, which include driving a motor vehicle. I am aware that if I choose to drive a vehicle I could be charged with a DUI.
10. I have been given information about the use of narcotic medications, including but not limited to, possible risks and adverse side effects such as the development of tolerance, dependence, addiction, withdrawal, constipation, nausea, itching, harmful effects to an unborn child, urinary retention, impairment of reasoning and judgment, and depression of breathing.
11. I will not combine any narcotic medications with the consumption of alcohol.
12. I will not give, trade or sell pain medications.
13. I will allow 24 hours for a prescription refill to be authorized. I also understand that requests received after 3:00 PM are handled on the next business day.
14. Only one pharmacy may be used for filling prescriptions. My pharmacy's name and location is:

____

Pharmacy's Phone Number: ____________________________________

I have read and understand the above policy and agree to abide by its terms.

______________________________	______________________________
Patient Signature	Date
______________________________	______________________________
Print Name	Date of Birth

Maternal Gynerations - New Patient

Name	Birthdate	Age
Preferred Name	Referred by	
Reason for visit: □ Routine Physical □ Problem	Describe problem:	
What are some questions you would like answered today?		

Your Medical History

Check if you have now or have ever had ANY of these in the past and when or at what age:

Major Illnesses	**YES/WHEN**		**YES/WHEN**
Anemia		HIV/AIDS	
Anxiety		Human Papilloma Virus/HPV	
Asthma		Hyperthyroid	
Bipolar disorder		Hypothyroid	
Blood transfusion, why		Irritable Bowel Syndrome	
Breast Cancer		Kidney Infection (not bladder or UTI)	
Cancer, what type		Kidney Stones	
Chickenpox		Lupus	
Chlamydia		Migraine Headaches	
Depression		MRSA	
Diabetes		Osteoporosis/Osteopenia	
Eating disorder and type		Pap smear abnormal	
Glaucoma		Pulmonary Embolus/DVT	
Gonorrhea		Rheumatoid arthritis	
Heart Disease		Seizure disorder	
Hepatitis/Liver Disease		Stroke	
Herpes/HSV		Syphilis	
High Cholesterol		TB-Tuberculosis	
High Blood pressure		Ulcers	
		UTI/bladder infection more than 2X/year	

Do you have any other problems we have not asked you about which you feel may be important?

Please list ALL hospitalizations and or surgeries you have had. List reason and dates.

Date Surgery/Hospitalization/Reason	Date Surgery/Hospitalization/Reason

Please list ALL medications and/or supplements that you are currently taking.

Drug name and dosage	Physician	List all "natural" or herbal remedies, over the counter drugs, vitamins or minerals you are taking.

ALLERGIES TO MEDICATIONS, LATEX GLOVES, ETC? □ NO □ YES	***What are you allergic to and what was the reaction you had?***

Your Family History

Check the problems that your blood relatives have had and list the affected family member. Use the following abbreviations: M-Mother; F-Father; B-Brother; S-Sister; MGM-mom's mom; MGF-mom's dad; PGM-dad's mom; PGF-dad's father; A-Aunt; U-Uncle

Disease	**Who**	**Disease**	**Who**
Alzheimer's		Hepatitis/Liver disease	
Breast Cancer		High Cholesterol	
Cancer (what type)		High Blood Pressure	
Colon Cancer		Osteoporosis	
Colon Polyps		Pulmonary embolism/DVT	
Depression/Mood Disorder (type?)		Stroke	
Diabetes		Thyroid disease	
Heart disease (type)		Other:	

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 OB History

Total # of pregnancies		Full term births	
Premature deliveries (less than 37 weeks)		Abortions/terminations	
Miscarriages		Living Children	

On the chart below please fill in the answers for each pregnancy including abortions or miscarriages

If you have had a tubal ligation, hysterectomy or are postmenopausal you may skip to the next section.

Birth	Wks	Labor	Baby Wt/Sex	Del Type	Epid	Preterm Wt	Comments/Complications	Hospital
1								
2								
3								
4								
5								

Your Social History

History of Abuse □ No □ Physical □ Emotional □ Sexual Did you receive counseling? □ Yes □ No

Age at first intercourse: __________

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?

Lifetime Sexual Partners: □ One partner only □ Less than 5 □ 5 or more

Are there any religious or cultural preferences that would affect your care? □ No □ Yes

Do you use seat belts □ Yes □ No

Occupation:

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