



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 _____



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



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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. #

MATERNAL GYNERATIONS - NEW PATIENT

Name	Birthdate	Age
Preferred Name	Referred by	
Reason for visit: <input type="checkbox"/> Routine Physical <input type="checkbox"/> 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

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 menstrual 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.

#	DOB	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 Separated 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/	Easy bruising	Lymph node enlargement				
LYMPHATIC:						

MATERNAL GYNERATIONS - OB

Name	Birthdate
Preferred Name	Age

GENETIC SCREENING

If you, the father of the baby, or any blood relative have had any of the following please indicate who.

Autism	Neural tube defect, spina bifida,	
Cystic fibrosis	anencephaly, menigomyelocele	
Down Syndrome	PKU	
Fragile X	Recurrent pregnancy loss or stillbirth	
Heart defect at birth and type	Sickle cell disease or trait	
Hemophilia	Used any medications, drugs, alcohol,	
Huntington chorea or disease	tobaco since your last period?	
Inherited genetic/chromosomal disorder	Tay Sachs disease	
Mental Retardation	Thalassemia	
Muscular dystrophy	Any other birth defects not listed above	

Mothers Race: White African American Hispanic Asian Other

Father of the baby's Race: White African American Hispanic Asian Other

YOUR SOCIAL HISTORY

Do you plan to breastfeed your baby? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have an infant car seat? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an infant car seat? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a cat? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you clean the litter box? <input type="checkbox"/> Yes <input type="checkbox"/> No
If you've had a Cesarean Section, do you want a repeat Cesarean Section? <input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you plan to take childbirth classes? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you have a son do you want him circumcised? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What do you plan to use for contraception after the birth of this baby?	
Do you plan to have an epidural for labor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the father of this baby involved in this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Father of Baby's Name:	
Do you have a pediatrician? <input type="checkbox"/> No <input type="checkbox"/> Yes Who?	
Do you want your tubes tied after the birth of this baby? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you planning any out of town trips during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What was your pre-pregnant weight?	