ADVANCED GYNECOLOGY

Staff Use Only: PID#:_____Scanned by (Initials)_____

Patient Arrival Time: _____

New Patient Registration

Demographics

Patient Information: Need help with forms? ☐ Y ☐ N | Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Name (LAST) _____ (FIRST) _____ (MI) _____ (Suffix) _____

Date of Birth: ____/_____/_____ Social Security: _____-_____-_____ Sex: ☐ M ☐ F Race: _____

Street Address: _____ (Apt. #) _____ (City) _____

(State) _____ (Zip) _____ Home Phone: _____Cell Phone: _____

Best form of contact: ☐ Home Phone ☐ Cell Phone Best Time: _____

May we leave a detailed voice message? ☐ Y ☐ N May we send a detailed email? ☐ Y ☐ N

Email: _____ Marital Status: _____ Ethnicity: _____

Primary Care Physician: (Name) _____ (Phone) _____

(Address) _____ (City) _____ (State) _____ (Zip) _____

Referring Physician: (Name) _____ (Phone) _____

(Address) _____ (City) _____ (State) _____ (Zip) _____

Preferred Pharmacy: (Name) _____ (Location) _____ (Phone) _____

Do you have a cardiologist? ☐ Y ☐ N Cardiologist Name: _____ (Phone) _____

Emergency Contact: (Name) _____ (Phone) _____(Relationship)_____

Do you live in an assistant living facility? ☐ Y ☐ N Name of facility: _____

(Address) _____ (City) _____ (State) _____ (Zip) _____

Do you have an Advance Directive (Living Will)? ☐ Y ☐ N

Employment

Employer: _____ Occupation _____

Phone _____ (Address) _____

(City) _____ (State) _____ (Zip) _____

ADVANCED GYNECOLOGY

Staff Use Only: PID#:_____Scanned by (Initials)_____

Patient Arrival Time: _____

Patient Authorization to Release Medical Records (To a Doctor or Family Member)

Patient Authorization to Release Medical Records: I authorize Advanced Gynecology to disclose/release the following information* (check all applicable):

☐ All Records ☐ Billing Records ☐ Other _____

Release to:

Facility Name: _____ (Address) _____ (Phone) _____ (Fax) _____

Name: _____ (Relationship) _____ (Phone) _____

Name: _____ (Relationship) _____ (Phone) _____

Name: _____ (Relationship) _____ (Phone) _____

Signature of patient (or guardian) _____ Date: _____/_____/_____

*__NOTES__:

- You may revoke this authorization at any time by writing to Advanced Gynecology
  1561 Janmar Rd., Snellville, GA 30078
  The revocation will become effective upon receipt of the notice.

- This authorization will remain in effect for a period of one (1) year

I have reviewed this authorization and confirm it is correct and would like to extend it for a period of one (1) year

ADVANCED GYNECOLOGY

Request for Healthcare information
Please forward the healthcare records of the following patient
Fax to 678.666.5201 or mail to 1561 Janmar Rd., Snellville, GA 30078

Authorization to obtain protected healthcare information

Patient Name (LAST) _____ (FIRST) _____ (MI) _____ (Suffix) _____

Date of Birth: _____/_____/_____ Phone: _____

☐ I authorize Advanced Gynecology to obtain and the named facilities to release to Advanced Gynecology my healthcare information.

This release applies to:

☐ All my healthcare information

☐ Healthcare information related to the following treatment, condition or dates

_____

☐ Other

_____

_____

For Office Use Only

Facility: (Name) _____

Address:

_____

Phone: _____

(Fax)_____

_____ _____/_____/_____

Signature of patient (or guardian) Date

_____ _____

Print name of person signing Relationship to patient

ADVANCED **GYNECOLOGY**

Patient Acknowledgement & Consent
Treatment Coverage & Communication

Please *initial and sign* to your acknowledgement and consent for Medical Treatment, Notice of Privacy Practices, and Payment Policy.

_____**PAYMENT POLICY**

Thank you for choosing Advanced Gynecology as your provider. We are committed to providing you with quality and affordable health care. Please be sure to carefully read our payment policy. A copy will be provided upon request.

- ***Insurance.*** We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- ***Co-payments and deductibles***. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If your account is turned over to a collection agency, a $100 collections processing fee will be added to any outstanding balance.
- ***Non-covered services***. Please be aware that some of the services you receive may be non- covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- ***Proof of insurance***. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- ***Claims submission***. We will submit your claims and assist you in any way we can to help get your claims paid. Please be aware that any unpaid balances are your responsibility.
- ***Coverage changes***. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- ***Nonpayment.*** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

_____**CONSENT TO MEDICAL TREATMENT**

- I voluntarily present for treatment and consent to my provider to provide my care. Such care may include, but is not limited to, diagnostic procedures, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care.
- I acknowledge that my treatment is intended to address specific illnesses and is not intended as a substitute for a primary care physician and that no guarantee can be made or has been made as to the results of treatments or examinations at Advanced Gynecology.

_____**NOTICE OF PRIVACY PRACTICES**

By signing this document, I acknowledge review of Advanced Gynecology's Notice of Privacy Practices, with a copy available upon request, as required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

_____ _____/_____/_____

Print name of person signing Date

_____ _____

Signature of patient (or guardian) Relationship to patient

NOTE: If you have any questions or would like copies of the payment policy or Notice of Privacy Practices, please see the front desk.

ADVANCED **GYNECOLOGY**

Patient History

REASON FOR TODAY'S VISIT	REASON FOR TODAY'S VISIT
Name:_____ **Date of Birth:**_____	**Please tell us the reason for your visit today:**

SYSTEM REVIEW

Have you experienced any of the following?

Constitutional		**Cardiovascular**		**Genito-Urinary**	
• Change in appetite	☐Y ☐N	• Cardiac murmurs	☐Y ☐N	• Decreased sex drive	☐Y ☐N
• Chills	☐Y ☐N	• Chest pains	☐Y ☐N	• Decreased stream	☐Y ☐N
• Fatigue	☐Y ☐N	• Irregular heartbeat	☐Y ☐N	• Difficulty voiding	☐Y ☐N
• Fever	☐Y ☐N	**Respiratory**		• Dysmenorrhea (painful periods)	☐Y ☐N
Eyes		• Painful respiration	☐Y ☐N	• Dysuria (painful urination)	☐Y ☐N
• Blurred vision	☐Y ☐N	• Shortness of breath	☐Y ☐N	• Frequency of urination	☐Y ☐N
• Changes in vision	☐Y ☐N	• Wheezing	☐Y ☐N	• Impotence	☐Y ☐N
ENT		**Allergic-Immunologic**		• Incontinence	☐Y ☐N
• Headaches	☐Y ☐N	• Allergic dermatitis	☐Y ☐N	• Nocturia (frequent urination at night)	☐Y ☐N
• Nasal congestion	☐Y ☐N	• Frequent illness	☐Y ☐N	• Post void dribbling	☐Y ☐N
• Runny nose	☐Y ☐N	• Sinus allergy symptom	☐Y ☐N	• Retention	☐Y ☐N
• Sinus pain	☐Y ☐N	**Gastrointestinal**		• Scrotal pain	☐Y ☐N
• Sore throat	☐Y ☐N	• Abdominal pain	☐Y ☐N	• Urgency	☐Y ☐N
Breast		• Blood in stool	☐Y ☐N	• Vaginal discharge	☐Y ☐N
• Additional symptoms	☐Y ☐N	• Diarrhea	☐Y ☐N	**Endocrine**	
• Lumps	☐Y ☐N	• Loss of appetite	☐Y ☐N	• Cold intolerance	☐Y ☐N
• Nipple discharge	☐Y ☐N	• Nausea	☐Y ☐N	• Excessive thirst	☐Y ☐N
• Swelling	☐Y ☐N	• Vomiting	☐Y ☐N	• Excessive urination	☐Y ☐N
• Tenderness	☐Y ☐N	**Musculoskeletal**		• Heat intolerance	☐Y ☐N
Neurological		• Back pain	☐Y ☐N	• Weight gain	☐Y ☐N
• Headaches	☐Y ☐N	• Bone pain	☐Y ☐N	• Weight loss	☐Y ☐N
• Incoordination	☐Y ☐N	• Joint pain	☐Y ☐N	**Hematology/Lymphatic**	
• Numbness or tingling	☐Y ☐N	• Muscle pain	☐Y ☐N	• Easy bleeding	☐Y ☐N
• Seizures	☐Y ☐N			• Easy bruising	☐Y ☐N
				• Lymph enlargement	☐Y ☐N

SOCIAL HISTORY

Tobacco Use

- Do you use tobacco products? ☐Y ☐N Type: _____ How long? _____ (How much) Packs/day: _____
- Are you a former smoker? ☐Y ☐N (How much) _____ packs/day for _____ years

Alcohol Use

- Do you consume alcohol? ☐Y ☐N Type: ☐Beer ☐Wine ☐Liquor Date of last drink: _____/_____/_____
- How much? _____ drinks per ☐Day ☐Week ☐Month

Caffeine ☐I do not drink caffeinated beverages	**Exercise** ☐I do not exercise
☐Current caffeine _____ drinks/day for _____ years	☐Exercise regularly _____minutes/day for ___ days/week

ADVANCED **GYNECOLOGY**

Patient History

ALLERGIES

- Do you have any known allergies? ☐ Y ☐N ☐I'm allergic to latex ☐ I'm allergic to band-aids ☐ Other
- List all medication allergies?

Name of medication	Reaction to medication

- List all other allergies:

CURRENT MEDICATION

List ALL current medications including over the counter, birth control, vitamins, herbals & prescriptions

Medication Name & Dose	Medication Name & Dose

PAST MEDICAL HISTORY

List ***ALL*** current or past medical conditions	List ***ALL*** surgeries including the year

PREGNANCIES

- Are you currently pregnant? ☐ Yes ☐ No ☐ Don't know Number of pregnancies: _____
- Number of Vaginal deliveries: _____ Caesarean deliveries: _____
- Date of last pap smear:_____ • Date of last period:_____ • Date of last mammogram:_____

FAMILY HISTORY

Do you or a family member have history of any of the following?

☐ Blood disease ☐ You ☐ Relative Relationship:	☐ Prostate enlargement ☐ You ☐ Relative Relationship:	☐ Thyroid disorder ☐ You ☐ Relative Relationship:
☐ Thyroid disorder ☐ You ☐ Relative Relationship:	☐ Urinary tract infections ☐ You ☐ Relative Relationship:	☐ Migraines ☐ You ☐ Relative Relationship:
☐ Eczema ☐ You ☐ Relative Relationship:	☐ Coronary Artery disease ☐ You ☐ Relative Relationship:	☐ Diabetes ☐ You ☐ Relative Relationship:
☐ Hyperlipidemia ☐ You ☐ Relative Relationship:	☐ Inflammatory bowel disease ☐ You ☐ Relative Relationship:	☐ Renal failure ☐ You ☐ Relative Relationship:
☐ Stroke ☐ You ☐ Relative Relationship:	☐ High Blood Pressure ☐ You ☐ Relative Relationship:	☐ Urinary tract stones ☐ You ☐ Relative Relationship:

☐ Cancer ☐ You ☐ Relative Type: _____ Relationship: _____ Type: _____
Relationship: _____ Type: _____ Relationship: _____ Type: _____

Other:

ADVANCED **GYNECOLOGY**

Bladder Survey

Name:	DOB:	Today's date:

Frequency

• How frequently do you urinate?	• How much are you bothered by frequent urination?	• How long have you had symptoms?
☐ Every hour or less	☐ Not at all	☐ Less than a year
☐ Every 1 – 2 hours	☐ Slightly	☐ 1 Year
☐ Every 3 – 4 hours	☐ Modestly	☐ 2 Years
☐ Every 5 – 6 hours	☐ Greatly	☐ 3 – 5 Years
☐ Not frequently		☐ Over 5 Years

Nocturia

How often do you get up at night?	How long have you had symptoms of nighttime urination?
☐ Every hour or less	☐ Never
☐ Every 1 – 2 hours	☐ Less than a year
☐ Every 3 – 4 hours	☐ 1 Year
☐ Every 5 – 6 hours	☐ 2 Years
☐ Not frequently	☐ 3 – 5 Years
	☐ Over 5 Years

Urgency

- Do you ever have the sudden or constant urge to urinate that is uncomfortable? ☐ Yes ☐ No
  - How often? ☐ Never ☐ Less than 6 months ☐ 6 months – 1 year ☐ 2 Years ☐ Over 5 Years

Difficulty Emptying

- Do you have difficulty emptying or feeling incomplete in emptying your bladder? ☐ Yes ☐ No
  - How long? ☐ Never ☐ Less than 6 months ☐ 6 months – 1 year ☐ 2 Years ☐ Over 5 Years
  - How much are you bothered by this? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly

Pad Usage

- Do you use pads or diapers for urinary leakage? ☐ Yes ☐ No
  - How many? ☐ 1-2 per day ☐ 2-4 per day ☐ 4-6 per day ☐ More than 6 per day
  - How much are you bothered by this? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly

Pelvic Pain

- Do you have pelvic pain? ☐ Yes ☐ No
  - How much are you bothered by this? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly

Medications

- Have you been prescribed medication(s) to treat overactive bladder? ☐ Yes ☐ No ☐ Not sure
  - Select medications you have tried ☐ Detrol LA ☐ Ditropan XL ☐ Elavil ☐ Elmiron ☐ Enablex ☐ Cardura ☐ Flomax ☐ Mybetriq ☐ Oxytrol Patch ☐ Vesicare
  - Select any side effects that applied to you ☐ Unable to urinate ☐ Dry eyes ☐ Dry mouth ☐ Constipation ☐ Difficulty emptying bladder ☐ I have Glaucoma ☐ Other_____

Other Therapies

- Have you tried lifestyle changes such as diet, exercise, and stress reduction? ☐ Yes ☐ No
- Have you tried bladder training? (following a fixed voiding schedule) ☐ Yes ☐ No
- Have you tried pelvic floor muscle physical therapy? ☐ Yes ☐ No

ADVANCED **GYNECOLOGY**

Bladder Survey

Stress Incontinence					
• Do you leak urine when you cough, sneeze, laugh or exercise?	☐ Yes	☐ No			
▪ How long?	☐ Never	☐ Less than 6 months	☐ 6 months – 1 year	☐ 2 Years	☐ Over 5 Years
▪ How much are you bothered by this?	☐ Not at all	☐ Slightly	☐ Moderately	☐ Greatly	
Urge Incontinence					
• Do you leak urine when you develop the urge to urinate and cannot make it to the bathroom?	☐ Yes	☐ No			
▪ How long?	☐ Never	☐ Less than 6 months	☐ 6 months – 1 year	☐ 2 Years	☐ Over 5 Years
▪ How much are you bothered by this?	☐ Not at all	☐ Slightly	☐ Moderately	☐ Greatly	
Incontinence Impact					
• Has urine leakage affected your ability to do household chores?	☐ Not at all	☐ Slightly	☐ Moderately	☐ Greatly	
• Has urine leakage affected your participation in social activities?	☐ Not at all	☐ Slightly	☐ Moderately	☐ Greatly	
• Has urine leakage affected your physical recreation?	☐ Not at all	☐ Slightly	☐ Moderately	☐ Greatly	
• Has urine leakage affected your emotional health?	☐ Not at all	☐ Slightly	☐ Moderately	☐ Greatly	
• Has urine leakage affected your entertainment activities?	☐ Not at all	☐ Slightly	☐ Moderately	☐ Greatly	
• Has urine leakage caused you to feel frustrated?	☐ Not at all	☐ Slightly	☐ Moderately	☐ Greatly	
• Has urine leakage affected your ability to travel by car or bus more than 30 minutes from home?	☐ Not at all	☐ Slightly	☐ Moderately	☐ Greatly	