OB/GYN Specialists of Savannah
600 East 70th Street
Savannah, Georgia 31405

Telephone (912) 355-7766
Fax (912) 692-0985

Date: _____

Patient Name: _____ D.O.B: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell: _____

Employer _____ Work Phone: _____

SSN: _____ Married: _____ Single: _____ Divorced: _____

Email Address: _____

Emergency Contact: _____ Phone:_____

Spouse's Name: _____ D.O.B: _____ Cell: _____

Responsible Party/ Guarantor Information

Name: _____ Primary Phone: _____

Relationship to Patient: _____ Work Phone: _____

Primary Insurance: _____ Group: _____ Policy #: _____

Policy Holder: _____ Policy Holder DOB: _____

Secondary Insurance: _____ Group: _____ Policy #: _____

AUTHORIZATION

I authorize examination and medical treatment to the above patient. Patient Initial: _____

I authorize all insurance benefits to be assigned to my physician. Patient Initial: _____

I authorize the release of any medical information required for treatment payment or healthcare options. Patient Signature: _____

I understand that I am responsible for the bill incurred by the above patient in the event that the insurance does not pay. Patient Signature: _____

It is the patient's responsibility to know which hospital and lab is covered by your insurance. OB/GYN Specialists will not be responsible if your labs are sent to the wrong facility.

Our office requires that you bring your insurance card and co-payment to every visit. If you do not bring your insurance card, you will be considered self-pay and you will be responsible for your charges. Payment will be expected in full on the date of service.

Insurance Company: _____

Referral required from Primary Care Doctor? Yes_____ No _____

My labs must be sent to _____ Laboratory.

My insurance company requires me to go to _____ Hospital.

I understand that pre-certification of services is not a guarantee of payment. I also understand that I am responsible for all related expenses.

Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

This notice was published and becomes effective on/or before April 14, 2003

(Name)_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out Treatment, Payment and Health Care Operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical and mental health condition and related health care services.

1. Uses and Disclosures of Protected Health Information (PHI)

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose you PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose or treat you.
Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations: We may use and disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk when you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your PHI.

- You have the right to inspect and copy our PHI. Under federal law; however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.
- You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

- Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

- You have the right to request to receive confidential communications from us by alternative means or at an alternate location. You have the right to obtain a paper copy of this notification from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

- You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- You have the right to receive and accounting of certain disclosure we have made; of any of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. Under no circumstances would our practice retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with this notice of your legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 912-355-7766.

Signature below is only acknowledgment that you have received the Notice of our Privacy Practices

(Print Name): _____

(Sign Name): _____

(Date): _____

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse: _____

Child(ren): _____

Other: _____

This release of information will remain in effect until terminated by me in writing.

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Gynecology Health History

Please use BLACK INK ONLY to complete this form

ID No.: _____

Today's Date: ____ / ____ / ____

PATIENT IDENTIFICATION *(Please print)*

Patient's Name: _____

Address: _____

_____

Home Telephone No: ( ) _____

Work Telephone No: ( ) _____

Reason for Seeing Doctor _____

Date of Birth: ____ / ____ / ____ Age: _____ Religion: _____

Marital Status: ❑ S ❑ M ❑ D ❑ SEP ❑ W Race: _____

Education: _____ years Occupation: _____

Employer: _____

Type of Insurance: _____ Policy #: _____

Referring Physician: _____

Primary Physician: _____

1. CURRENT MEDICATIONS ❑ None

_____

_____

_____

2. MEDICATION ALLERGY / SENSITIVITY

List all medications allergic to: ❑ None

_____

_____

_____

MEDICAL HISTORY *(Check the appropriate box)*

Have you or any members of your family had:	You	Your Family
3. High Cholesterol	❑	❑
4. Heart Disease	❑	❑
5. Rheumatic Fever	❑	
6. High Blood Pressure	❑	❑
7. Asthma	❑	
8. Tuberculosis	❑	
9. Diabetes	❑	❑
10. Thyroid Problems	❑	❑
11. Liver Disease	❑	
12. Stomach, Bowel or Gall Bladder Problems	❑	
13. Kidney or Bladder Problems	❑	
14. AIDS (HIV)	❑	❑
15. Hepatitis (type ____)	❑	❑
16. Anemia or Blood Disorder	❑	❑
17. Blood Transfusion	❑	
18. Allergies	❑	
19. Breast Problems	❑	❑
20. Cancer	❑	❑
21. Infertility	❑	
22. Female or Sexual Problems	❑	
23. Chlamydia	❑	
24. Gonorrhea	❑	
25. Herpes (HSV)	❑	
26. Syphilis	❑	
27. Birth Defects or Inherited Diseases	❑	❑
28. Sexual Abuse or Domestic Violence	❑	❑
29. Other Medical Problems	❑	❑
30. **No Known Medical Problems**	❑	❑

31. HOSPITALIZATIONS

List those operations/serious illnesses that have required hospitalization. If more than six, check this box. ❑ *Do not include pregnancies here.*

Month/Year	Illness or Operation	Complications Yes	Complications No
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑

SUBSTANCE USE *(Check only those you use)*

32. Alcohol ❑
Type _____
Amt/day _____

33. Tobacco ❑
Type _____
Amt/day _____

34. Caffeine ❑
Type _____
Amt/day _____

35. Non-Prescribed Drugs ❑
Type _____
Amt/day _____
Type _____
Amt/day _____

36. Street Drugs ❑
Type _____
Amt/day _____
Type _____
Amt/day _____

37. PREGNANCY HISTORY *(Complete all information)*

# of Pregnancies	# of Premature Births	# of Miscarriages	# of Spontaneous Abortions	# of Induced Abortions	# of Living Children

# of Term Births	Born Month/Year	Baby's Sex	Weight at Birth	Weeks Pregnant (Term= 40Wks)	Hours in Labor	Type of Delivery	Type of Anesthesia	Complications Yes	Complications No
1	/		lbs. oz.					❑	❑
2	/		lbs. oz.					❑	❑
3	/		lbs. oz.					❑	❑
4	/		lbs. oz.					❑	❑
5	/		lbs. oz.					❑	❑

38. MENSTRUAL HISTORY

First Day of Last Menstrual Period ____ / ____ / ____

Menarche (Age at First Period)	Interval (No. of Days Between Periods)	Length of Period
years	days	days

Abnormalities: ❑ Excessive Bleeding ❑ Discharge ❑ Pain ❑ None

39. CONTRACEPTIVE HISTORY

Type	Dates Used
Oral Contraceptive ❑	
Type(s) _____ ❑	
_____ ❑	
IUD ❑	
Diaphragm ❑	
Norplant ❑	
Sponge ❑	
Spermicide ❑	
Condoms ❑	
Other _____ ❑	

Sterilization ❑ Male ❑ Female

LIFESTYLE

	Yes	No
40. Dtd your mother take DES or any other hormones when pregnant with you?	❑	❑
41. Have you ever had a Pap test?	❑	❑
If Yes: Date of your last Pap test? ____ / ____ / ____		
Have you ever had abnormal Pap test results?	❑	❑
42. Are you sexually active?	❑	❑
43. Do you have one partner or	❑	one
many partners	❑	many
44. Is intercourse painful for you?	❑	❑
45. Do you do a monthly self breast exam?	❑	❑
46. Have you ever had a mammogram?	❑	❑
If Yes: Date of your last mammogram? ____ / ____ / ____		
47. Do you exercise on a regular basis?	❑	❑

If Yes: Type of exercise _____

Hours per week exercise _____

Signature: _____

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Initial Gynecology Profile

Patient's Name: _____

ID No.: _____

This page is for the physician ONLY! Do not complete!

INITIAL PHYSICAL EXAM

1. Height _____
2. Weight _____
3. Blood Pressure _____

Pelvic Exam	Normal	Abn.	N.E.
4. Ext. Genitalia			
5. Urethral Meatus			
6. Urethra			
7. Bladder			
8. Vagina			
9. Cervix			
10. Uterus (describe)			
11. Adnexa/Parametria			
12. Rectum (Digital Exam)			
13. Anus and Perineum			
14. Other			
General Physical	Normal	Abn.	N.E.
15. Skin			
16. HEENT			
17. Neck			
18. Chest			
19. Breasts			
20. Heart			
21. Lungs			
22. Abdomen			
23. Musculoskeletal			
24. Extremities			
25. Neurological			

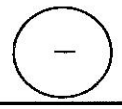
N.E. = Not Evaluated

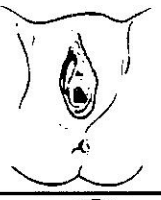
Nutritional Assessment

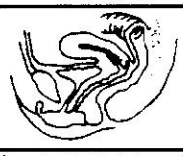
26. Not performed..... ❑
27. Apparently adequate ..... ❑
28. Apparently inadequate..... ❑
29. Excessive caloric intake ..... ❑

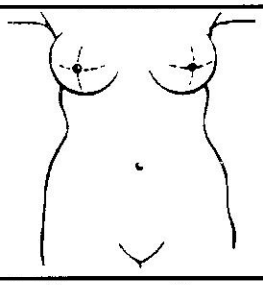
LABORATORY PROCEDURES

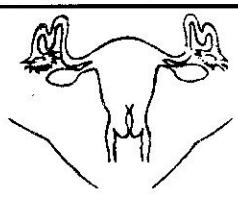
Test	Date	Result
30. Hgb	/	
31. Hct	/	
32. WBC	/	
33. Differential	/	
34. Pregnancy Test	/	
35. Urinalysis	/	
36. HIV	/	
37. Gonorrhea	/	
38. Chlamydia	/	
39. HSV	/	
40. VDRL Serology	/	
41. Hepatitis ___	/	
42. Pap Test	/	
43. Wet Mount	/	
44. Culture	/	
45. Stool Occult Blood	/	
46. Blood Glucose	/	
47. Cholesterol	/	
48. Thyroid Screen	/	
49. Biopsy	/	
50. Mammogram	/	
51.	/	
52.	/	
53.	/	
54.	/	











Diagnosis and Treatment Plans

Next Appointment: ___ /___/___ Signature: _____