Drs. Pope, Kehl, Barnes and Durso
Midwives of Macon
1062 Forsyth St, Suite 3B, Macon, Ga 31201
(478) 743-3454 www.pkbdobgyn.com

PATIENT INFORMATION

Patient Name: ______________________________ **Date of Birth:** ______________

Social Security #: ______________ **Race:** ______________ **Marital Status:** ______________

Address: ______________________ **City:** ______________ **State:** _____ **Zip:** _________

Home Phone: ______________ **Cell Phone:** ______________ **Work Phone:** ______________

Email Address: ______________________________ **Last Flu Vaccine (Mo/Yr):** _________

Pharmacy Name & Location: ______________ **Primary Care Physician:** ______________

Employer Name: ______________________ **Occupation:** ______________

Employer Address: ______________________ **City:** ______________ **State:** _____ **Zip:** _________

INSURANCE INFORMATION

Primary Insurance Carrier: ______________________ **Policy Holder Same As Patient** ☐

Policy Holder Name: ______________ Date of Birth: _________ Social Security #: ______________

Employer Name: ______________________ Occupation: ______________

Employer Address: ______________________ City: ______________ State: _____ Zip: _________

Secondary Insurance Carrier: ______________________ **Policy Holder Same As Patient** ☐

Policy Holder Name: ______________ Date of Birth: _________ Social Security #: ______________

Employer Name: ______________________ Occupation: ______________

Employer Address: ______________________ City: ______________ State: _____ Zip: _________

EMERGENCY INFORMATION

Emergency Contact Name: ______________________ Relationship: ______________

Phone #: ______________________ Alternate Phone #: ______________________

Patient Signature: ______________________ **Date:** ______________

Responsible Party Signature: ______________________ **Relationship:** ______________

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

Please Complete Reverse Side

Drs. Pope, Kehl, Barnes & Durso
Midwives of Macon

AUTHORIZATIONS

- I hereby authorize and request medical treatment necessary for the care of the above named patient as determined by the Physician, including checking my external prescription history.
- I authorize the release of all medical records and appeals to the referring physicians, family physicians, and to my insurance company, if applicable. I allow the fax transmittal of my records if necessary. I also acknowledge that my doctors office will share my medical information, as permitted under federal law (HIPAA) and Georgia State law, with my healthcare providers through a health information exchange.
- I acknowledge full responsibility for any services rendered by Drs. Pope, Kehl, Barnes, Durso & Midwives of Macon. I understand that any co-payment I have with my insurance company is due at the time of service. I understand that I am financially responsible for payment of any co-insurance, un-met deductible, or non-covered services, as deemed by my insurance company, within a timely manner.
- I further authorize and request that insurance payments be made directly to Drs. Pope, Kehl, Barnes, Durso, & Midwives of Macon for all services rendered.

LAB WAIVER

Certain lab specimens are sent to outside labs for processing. We will send the specimen to the laboratory that participates with your insurance carrier, to the best of our knowledge**. If your specimen is sent to the wrong lab, Drs. Pope, Kehl, Barnes, Durso, and Midwives of Macon will not be responsible for any fees incurred for processing**. I understand that it is my responsibility to know which laboratory my insurance authorizes, and to notify Drs. Pope, Kehl, Barnes, Durso & Midwives of Macon's staff of this information.

AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following individuals the right to obtain any information; including: lab results, appointment information, or any other diagnostic testing performed by Drs. Pope, Kehl, Barnes, Durso & Midwives of Macon.

Name: ____ Relationship to patient: __________________________

Name: ____ Relationship to patient: __________________________

ACKNOWLEDGEMENT OF PRIVACY NOTICES (HIPAA) AND DISCLOSURE OF HEALTH INFORMATION

I understand that the patient's health information is private and confidential. I understand that Drs. Pope, Kehl, Barnes, Durso & Midwives of Macon work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. I understand that Drs. Pope, Kehl, Barnes, Durso & Midwives of Macon may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I permit it

Drs. Pope, Kehl, Barnes, Durso, & Midwives of Macon have a detailed document called the "Notice of Privacy Practices" in which contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement.

My signature below indicates that I have been given the opportunity to review a current copy of Drs. Pope, Kehl, Barnes, Durso & Midwives of Macon "Notice of Privacy Practices", and that I agree to allow Drs. Pope, Kehl, Barnes, Durso & Midwives of Macon to use and disclose the patient's health information to carry out treatment, payment from insurance companies, and all healthcare operations.

____ ________________________

Patient and/or Guardian Signature Date

Patient Name: ____________________

Today's Date:_________________________

Medication List

Prescription and over the counter	Strength	Frequency

Drug Allergies

Surgical History Since Last Visit

Date	Type of Surgery

Risk Assessment for Hereditary Cancers

Patient Name: ______________________ Provider: ______________________

Date of Birth: ______________________ Today's Date: ______________________

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY – BOTH MOM AND DAD'S SIDE OF THE FAMILY. Include any of the below family members:

Yourself Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather First Cousin

If you do not know the exact age of diagnosis for your family member, you may enter a ***best guess*** *or a decade. For example, "40s" or "60s"*

		YOU?	Which Family Member?	Mom's side or Dad's side?	Age at diagnosis
Y N	Breast cancer before age 50	______	______	______	______
Y N	3 or more breast cancers on	______	______	______	______
	the same side of the family	______	______	______	______
		______	______	______	______
Y N	Breast cancer in both breasts or breast cancer twice in same person	______	______	______	______
Y N	Male breast cancer	______	______	______	______
Y N	Ovarian cancer	______	______	______	______
Y N	Colorectal cancer before age 50	______	______	______	______
Y N	Endometrial (Uterine) cancer before age 50	______	______	______	______
Y N	3 or more Colon, Endometrial,	______	______	______	______
	Ovarian, Brain, Gastric, Pancreatic,	______	______	______	______
	Small Bowel, Renal/Pelvic cancers on the same side of the family	______	______	______	______

Y N Ashkenazi Jewish ancestry with a family member with breast, ovarian, or pancreatic cancer at any age?

Y N Have YOU ever had endometrial (uterine) cancer, regardless of age of diagnosis? List age: ______

Y N Have you or any member of your family ever been tested for BRAC or Lynch Syndrome?
If yes, please explain: ______________________

____
Patient's Signature Date

FOR OFFICE USE ONLY:

Patient offered genetic testing:

Accepted ________ Declined ________ Not Applicable

Follow-up appointment scheduled:

Date: ____________

____
Health Care Provider's Signature Date