Women of Camden Advanced OBGYN
2060 Dan Proctor Dr Suite 1800
Saint Marys, GA 31558
Phone (912)510-7376 FAX (912)510-7377

NEW PATIENT/ ANNUAL REGISTRATION INFORMATION DATE _____

NAME: _____ DOB _____ AGE _____
(LAST, FIRST, MIDDLE)

MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____

PHYSICAL ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____
WORK PHONE: _____

EMPLOYER/SCHOOL: _____ OCCUPATION: _____
SOCIAL SECURITY: _____ DRIVER'S LICENSE: _____
MARITAL STATUS: _____

RESPONSIBLE PARTY'S NAME: _____ DOB _____
RELATIONSHIP: _____
SSN: _____ PHONE: _____
EMPLOYER _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP _____
PHONE _____

NAME OF PRIMARY INSURANCE: _____
NAME OF INSURED: _____
DOB of INSURED: _____ ID # _____ GROUP # _____

PRIMARY CARE PHYSICIAN: _____
WHO MAY WE THANK FOR REFERRING YOU TO THIS PRACTICE _____

ARE YOU HERE TODAY FOR A: ROUTINE ANNUAL EXAM Y/N PREGNANCY Y/N
PROBLEM Y/N OTHER Y/N

IF YOUR VISIT IS FOR A PROBLEM OR OTHER, PLEASE DESCRIBE _____

RELEASE OF MEDICAL INFORMATION

I,the undersigned as the patient or her authorized representative, do hereby authorize Women of Camden Advanced OBGYN, to release to my insurance company(ies) or other appropriate agency(ies) that information which is necessary to validate this claim. Women of Camden Advanced OBGYN is also hereby authorized to release to my physician(s), either as an individual or as a professional association, who perform services for me, the patient, on a fee for service basis such information as is necessary for billing purposes.

ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY

I do hereby authorize payment of all insurance benefits, basic and major medical for these services, to be made directly to Women of Camden Advanced OBGYN. For and in consideration of services rendered, I hereby agree to pay Women of Camden Advanced OBGYN for all charges not covered by insurance payments. I agree to pay all costs of collecting, securing, or attempting to collect or secure, including reasonable attorney fees or Collection Agency fees not exceeding 33.33% of the unpaid debt, whether suit be necessary or otherwise.

** THERE WILL BE A $20 RETURNED CHECK FEE**

STATEMENT TO PERMIT MEDICARE BENEFITS TO PROVIDERS AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or Women of Camden Advanced OBGYN on my behalf for any service furnished to me by Women of Camden Advanced OBGYN, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

ACCESS TO MY RECORD

I authorize Women of Camden Advanced OBGYN to discuss or release any of my medical information to the following individuals:

Name:_____Relationship:_____Phone Number:_____

Name:_____Relationship:_____Phone Number:_____

Name:_____Relationship:_____Phone Number:_____

Name:_____Relationship:_____Phone Number:_____

I authorize Women of Camden Advanced OBGYN to leave a detailed message with the phone numbers provided in regards to: (initial if desired)

____Appointment times ____Lab/Test results ____Billing issues

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO CONSULTING PHYSICIANS

I hereby authorize Women of Camden Advanced OBGYN to release any medical information to physicians other than referring physicians, who may be involved in my health care treatment, when requested by those physicians. By signing this consent, authorization will be given to requesting physicians without further signed authorization.

RESPONSIBILITY FOR PERSONAL PROPERTY

I understand that Women of Camden Advanced OBGYN does not assume responsibility for personal property.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Women of Camden Advanced OBGYN's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of this Notice, and I request the following restriction(s) concerning the use of my personal medical information. Further, I permit a copy of this authorization to be used in place of the original when deemed necessary.

Instructions:_____

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____ _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE RELATIONSHIP DATE

Women of Camden Advanced OBGYN

Patient History Questionnaire

Patient Name _____

Obstetric History

Total # of pregnancies_____ Vaginal or C-Section
Delivery date and weight of child(ren)_____ _____
_____ _____
Total # of miscarriages_____ Year(s) and weeks gestation_____
Full term pregnancies_____ D&C_____ Elective abortions yes/no Year(s)_____

Menstrual history

N/A

Date of last menstrual period_____ Age of first period_____ Frequency of period_____
Duration of period_____ Amount of flow_____
Symptoms associated with period_____
Last pap smear_____
Result: Normal/Abnormal, treatment and year_____

Menopausal Symptoms

yes/no

Date/Approx. date symptoms appeared:_____ Age at Menopause:_____
Taking Hormone Replacement Therapy (HRT): yes/no
Additional Menopausal comments:_____
Last mammogram_____ Results_____
Mammogram comments_____

Sexual History

N/A

Sexual performance and satisfaction:
Concerns:_____
Sexual Activity:
Currently active/not currently active Sexual preference: Male Female Bisexual
Number of partners:
Last 6 months_____ Last year_____ Last 2 years_____ Lifetime_____
Current contraception_____

Personal Past Medical History

No medical history

Asthma	Y/N	Lupus/Collagen Vascular Disease	Y/N
Lung Disease/Pneumonia	Y/N	Eating Disorder	Y/N
Kidney Infections/Stones	Y/N	Chicken Pox	Y/N
Tuberculosis	Y/N	Cancer & Type	Y/N
Herpes	Y/N	Reflux/Stomach Ulcer	Y/N
Other Sexually Transmitted Diseases	Y/N	Depression/Anxiety	Y/N
HIV/AIDS	Y/N	Anemia	Y/N
Heart Attack/Angina	Y/N	Blood Transfusion	Y/N
High Cholesterol	Y/N	Seizures	Y/N
Diabetes	Y/N	Bowel Problems	Y/N
High Blood Pressure	Y/N	Glaucoma	Y/N

Stroke	Y/N	Cataracts	Y/N
Rheumatic Fever	Y/N	Arthritis/Joint Problems	Y/N
Blood Clots in Legs or Lungs	Y/N	Osteoporosis	Y/N
Broken Bones	Y/N	Hepatitis/Liver Disease	Y/N
Thyroid Disease	Y/N	Gallbladder Disease	Y/N
Headaches	Y/N		

Other_____

Explanation to above questions answered 'Yes'_____

_____

Hospitalizations/Surgeries No past surgical history/hospitalizations

Reason hospitalized/Procedure, Date of hospitalization/procedure, Complications

_____

_____

Other_____

Current Medications (with Dosage and How Often Taken)

_____

_____

_____

Medication Allergies and Reactions

_____

_____

Pharmacy of choice

_____

Social History

Smoking status _____Never _____Current _____Past
Packs Per Day _____ # of years _____ Smoking Cessation Y/N
Illegal Drug Use _____Never _____Current _____Past
Alcohol Use None/Social # Drinks Per Day_____ #Drinks Per Week_____
Caffeine Use Y/N Quantity_____
Employment Status: Unemployed Part Time Full Time Student
Occupation:_____
Number of hours worked:_____

Family History

MOTHER	LIVING/DECEASED	AGE DECEASED_____	DIED FROM_____
FATHER	LIVING/DECEASED	AGE DECEASED_____	DIED FROM_____

For the following, indicate nearest relative (mother, father, grandparents, sibling, children)
ILLNESS

Birth defects _____
Alcohol or drug addiction _____
Breast cancer _____
Ovarian cancer _____
Uterine cancer _____

Colon cancer _____
Other cancers _____
Mental illness/depression _____
Alzheimer's disease _____
Other _____

Chief complaint/reason for your visit today

_____

Review of Systems Indicate yes or no

Constitutional
1. Unexplained weight loss Y/N
2. Unexplained weight gain Y/N
3. Fever Y/N
4. Fatigue Y/N
5. Change in height Y/N

Eyes
1. Double vision Y/N
2. Spots before eyes Y/N
3. Vision changes Y/N
4. Glasses/contacts Y/N

Ear, nose, throat
1. Earaches Y/N
2. Ringing in ears Y/N
3. Hearing problems Y/N
4. Sinus problems Y/N
5. Sore throat Y/N

Cardiovascular
1. Pain with breathing Y/N
2. Chest pain Y/N
3. Shortness of breath Y/N
4. Irregular heartbeat Y/N

Respiratory
1. Wheezing Y/N
2. Spitting up blood Y/N
3. Chronic cough Y/N

Gastrointestinal
1. Diarrhea Y/N
2. Bloody stool Y/N
3. Nausea/vomiting Y/N
4. Constipation Y/N
5. Involuntary loss of stool Y/N

Endocrine
1. Hair loss Y/N
2. Heat/cold intolerance Y/N
3. Abnormal thirst Y/N
4. Hot flashes Y/N

Genitourinary
1. Blood in urine Y/N
2. Pain with urination Y/N
3. Strong urgency to urinate Y/N
4. Frequent urination Y/N
5. Incomplete bladder elimination Y/N
6. Involuntary loss of urine Y/N
7. Urine loss with cough/strain Y/N
8. Abnormal vaginal bleeding Y/N
9. Painful periods Y/N
10. Painful intercourse Y/N
11. Fibroids Y/N
12. Endometriosis Y/N
13. Infertility Y/N
14. Abnormal vaginal discharge Y/N

Musculoskeletal
1. Muscle weakness Y/N
2. Muscle or joint pain Y/N

Skin
1. Rash Y/N
2. Sores Y/N
3. Dry skin Y/N
4. Moles Y/N

Neurological
1. Dizziness Y/N
2. Seizures Y/N
3. Numbness Y/N
4. Trouble walking Y/N
5. Severe memory problems Y/N
6. Severe headaches Y/N

Psychiatric
1. Depression Y/N
2. Severe Anxiety Y/N

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician: _____

Date of Birth: _____ Today's Date: _____

This is a screening tool for cancers that run in families. Please consider these family members when completing the form:

Mother/Father/Sister/Brother/Children = **1st Degree Relatives**

Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Relatives** Cousin/Great Grandparent = **3rd Degree Relatives**

Have you or any of your relatives been tested for hereditary cancer (BRCA/Colaris) in the past? YES NO

		COLON AND UTERINE CANCER (Lynch Syndrome/Colaris)	SELF	YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
(Y)	N	***EXAMPLE: Two or more relatives with a Lynch syndrome cancer; one under age 50***			***Aunt-colon Sister-uterine***	***47 yrs 60 yrs***
Y	N	Have **YOU** been diagnosed with uterine (endometrial) or colorectal cancer before age 50				
Y	N	Two or more relatives on the same side of the family w/ any of the following, one diagnosed before 50 (**please circle**): *colon, uterine/endometrial, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter and renal pelvis*				
Y	N	Three or more relatives on the same side of the family w/ any of the following diagnosed at any age (**please circle**): *colon, uterine/endometrial, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter and renal pelvis*				
Y	N	Family member has a known Lynch syndrome mutation				

		BREAST AND OVARIAN CANCER (HBOC/BRACAnalysis)	SELF	YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	N	Ovarian cancer at any age (in self, first or second degree family members)				
Y	N	Two relatives on the same side of the family with breast cancer—with one under the age of 50				
Y	N	Three relatives on the same side of the family with breast cancer at any age				
Y	N	Multiple breast cancers in the same person (in the same breast or in both breasts)				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family				
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family				
Y	N	Triple Negative breast cancer under age 60 (ER, PR and Her2 negative receptor status)				
Y	N	A family member with a known BRCA mutation				

Is there any other cancer in you or any family members not listed above (provide site, relationship and age):

_____

Patient's signature: _____ **Date:** _____

FOR OFFICE USE ONLY

☐ Patient is appropriate for further risk assessment and/or genetic testing

☐ Information given to patient to review Follow-up appointment scheduled on _____

Patient offered genetic testing: Accepted OR Declined HCP Signature: _____