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 REGISTRATION INFORMATION DATE_____

NAME:_____DOB:_____AGE:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

HOME #:_____CELL #:_____WORK #:_____

EMPLOYER/SCHOOL:_____OCCUPATION:_____

SOCIAL SECURITY #:_____MARITAL STATUS:_____

RESPONSIBLE PARTY NAME(if pt is under 18):_____

RELATIONSHIP:_____SOCIAL SECURITY#:_____

PHONE #:_____

NAME OF PRIMARY INSURANCE:_____

POLICY/ID#_____GROUP #_____

NAME OF INSURED:_____DOB:_____

NAME OF SECONDARY INSURANCE:_____

POLICY/ID#_____GROUP #_____

NAME OF INSURED:_____DOB:_____

PRIMARY CARE PROVIDER:_____

REASON FOR TODAY'S VISIT:_____

IF YOUR VISIT IS FOR A PROBLEM, PLEASE DESCRIBE:_____

RELEASE OF MEDICAL INFORMATION

I, the undersigned as the patient or her representative, do hereby authorize Women of Camden Advanced OBGYN, to release 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, court costs and expenses or Collection Agency fees, and interest, whether suit be necessary or otherwise.

*******THERE WILL BE A $40 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 and 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 #:_____

Name:_____Relationship:_____Phone #:_____

Name:_____Relationship:_____Phone #:_____

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

AUTHORIAZTION 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 as Federal and State Law. I understand the contents of the 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.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____ _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE (if patient is under 18) RELATIONSHIP TO PATIENT DATE

WOMEN OF CAMDEN ADVANCED OBGYN
Patient History Questionnaire

Obstetric History

Total Pregnancies _____ Abortion Induced _____ Ectopics _____
Full Term Births (> 37 weeks)_____ Abortion Spontaneous_____ # of Living Children_____
Premature Births _____ Multiple Births _____
Delivery date & weight of children(ren)_____Vaginal or C-Section
_____Vaginal or C-Section
_____Vaginal or C-Section
_____Vaginal or C-Section

Menstrual History **N/A**

Date of last menstrual period_____ Age of first period_____ Frequency of period_____
Duration of period_____ Amount of flow_____(light/moderate/heavy)
Symptoms associated with period_____
Last pap smear_____ Results: Normal/Abnormal, treatment and year_____
Current contraception_____

Menopausal Symptoms **yes/no**

Date/Approx. date symptoms appeared_____ Age at menopause_____
Taking Hormone Replacement Therapy (HRT): yes/no
Date of last mammogram_____ Results_____

Sexual History	**Please circle one**
Sexual Identification	Female/Male/Other
Sexual Performance and Satisfaction	yes/no
Sexual Activity	Never/Current/Past
Sexual preference	Spouse/Significant other/Male/Female

Age at 1st intercourse_____
# of lifetime partners_____

Infection History

	Please circle one	**Explain (if you circled yes)**
Exposure to TB	yes/no	_____
Pt or partner with genital herpes	yes/no	_____
Hepatitis B or C	yes/no	_____
STD's	yes/no	_____
Rash/Viral illness since last LMP	yes/no	_____

Preventive Screening Dates	**Results**(if applicable)
Last Mammogram	_____
Bone Density Screening	_____
Colonoscopy	_____
Screening lab work	_____
Skin screening	_____

Past Medical History **Please circle yes or no**

Asthma	yes/no	Depression/Anxiety	yes/no
Lung disease	yes/no	Anemia	yes/no
Kidney infection/Stones	yes/no	Blood Transfusion	yes/no
Tuberculosis	yes/no	Seizure	yes/no
Herpes	yes/no	Bowel Problems	yes/no
Other Sexually Transmitted Diseases	yes/no	Glaucoma	yes/no
HIV/AIDS	yes/no	Stroke	yes/no
Heart Attack/Angina	yes/no	Rheumatic Fever	yes/no
High Cholesterol	yes/no	Blood Clots in legs or lungs	yes/no
Diabetes	yes/no	Broken Bones	yes/no
High Blood Pressure	yes/no	Thyroid Disease	yes/no
Lupus/Collagen Vascular Disease	yes/no	Headaches	yes/no
Eating Disorder	yes/no	Cataracts	yes/no
Chicken Pox	yes/no	Arthritis/Joint Problems	yes/no
Cancer & Type	yes/no	Osteoporosis	yes/no
Reflux/Stomach Ulcer	yes/no	Hepatitis/Liver Disease	yes/no
Gallbladder Disease	yes/no		

Other_____

Explanation to above questions answered "yes"_____

_____

Hospitalizations/Surgeries (if applicable)

Reason/Procedure	**Date**	**Complications if any**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications (with dosage and how often taken)

_____

_____

_____

Medication Allergies and Reactions

_____

_____

Pharmacy _____

Social History **Please circle one**

Marital Status	single/married/divorced/separated/widowed	
Alcohol Use	none/social	# of Drinks per week_____
Smoking Status	never/current/past	
Illegal Drug Use	never/current/past	
Caffeine Use	yes/no	
Employment Status	part time/full time/unemployed/student	
Occupation	_____	# of hours worked_____

Family History

Mother Living/Deceased Age Deceased_____ Cause of Death_____
Father Living/Deceased Age Deceased_____ Cause of Death_____

For the following, indicate nearest relative (mother, father, grandparents, siblings, 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

_____

Generalized Symptoms	**Please circle yes or no**
Anxiety	yes/no
Depression	yes/no
Diabetes	yes/no
Fatigue	yes/no
High Cholesterol	yes/no
Nervousness	yes/no
Seizures	yes/no
Sleep Disorders	yes/no
Stress	yes/no
Substance Abuse	yes/no
Thyroid-Overactive	yes/no
Thyroid-Underactive	yes/no
Urinary	
Painful urination	yes/no
Urinary Incontinence	yes/no
Urinary Urgency	yes/no
Musculoskeletal	
Back Pain	yes/no
Joint Pain	yes/no
Muscle Cramps	yes/no
Gynecological	
Cervical Disease	yes/no
Genital Sores	yes/no
Heavy Bleeding	yes/no
Vaginal Discharge	yes/no
Vaginal Itching	yes/no
Vaginal Odor	yes/no

Head/Ear/Nose/Throat	**Please circle yes or no**
Earaches or Drainage	yes/no
Headache	yes/no
Hearing Loss or Ringing	yes/no
Sinus Problems	yes/no
Vision Changes	yes/no
Respiratory	
COPD	yes/no
Shortness of Breath	yes/no
Wheezing	yes/no
Cardiovascular	
Chest Pain	yes/no
Congestive Heart Failure	yes/no
Heart Attack	yes/no
Heart Murmur	yes/no
Hypertension	yes/no
Gastrointestinal	
Abdominal Pain	yes/no
Constipation	yes/no
Diarrhea	yes/no
Heartburn	yes/no
Do you have any of the following:	
Bloating	yes/no
Breast Tenderness	yes/no
Cramping	yes/no
Moodiness	yes/no

For Patients with Commercial Insurance, Medicaid, or Medicare with a secondary plan

Personal & Family Cancer History

Name: _____ Date: _____ Date of Birth: _____ Age: _____

If you have the following insurance, call for information on coverage before moving forward with cancer genetic testing:
☐ *Medicare with no secondary insurance*

Complete the section below. Include yourself and all 1st and 2nd degree male and female blood relatives on both your mother's and father's sides. Specify which relatives were affected and estimate ages of diagnosis to the best of your ability.

1st Degree Relatives: Parents, Siblings, Children
2nd Degree Relatives: Grandparents, Aunts/Uncles, Nieces/Nephews

		CANCER HISTORY	You	Siblings/ Children	Mother's Side	Father's Side	Age of Diagnosis
No	Yes	BREAST CANCER in family member diagnosed age 49 or younger					
No	Yes	OVARIAN CANCER in you or a family member					
No	Yes	*Personal* History of Breast Cancer					
No	Yes	PANCREATIC CANCER in a family member, any age					
No	Yes	3 or more BREAST and/or PROSTATE, on one family side, any ages					
No	Yes	Ashkenazi Jewish heritage with a BREAST CANCER at any age					
No	Yes	3 or more COLON or UTERINE CANCERS on a family side, any ages					

Patient Signature _____

OFFICE USE ONLY Patient offered genetic testing: Yes / No Accepted / Declined Provider Initials: _____