

# OB-GYN Associates, P.A.

- Marietta Office  
 Towne Lake Office

## Patient Registration Form

DATE / /

Physician (Please check one)  
 Dr. Espy  Dr. Kelley  Dr. Huffman  Dr. Windom  Dr. Chappell  Dr. Tackitt  \_\_\_\_\_

**When calling for today's appointment:**

Were you assigned one of the doctors by our receptionist, or  
 Did you choose the doctor you wished to see.

### PATIENT INFORMATION

Patient Name (First, M.I., Last)		Social Security #	Date of Birth	Marital Status
		- -	/ /	
Address			Apt # - Lot # - Bldg # - C/O	
City	State	Zip Code	Home Phone	
			( ) -	
Who referred you to this practice?			Cell Phone	
			( ) -	

### PATIENT EMPLOYMENT INFORMATION

Name of Employer		Full Time / Part Time?	Work Phone
			( ) -
Address of Employer		Suite #	
City	State	Zip Code	Occupation

### RESPONSIBLE PARTY

Insured Name (First, M.I., Last)		Social Security #	Relationship to Patient
		- -	
Name of Employer		Date of Birth	Work Phone
			( ) -

### INSURANCE INFORMATION

Name of Primary Insurance Company		Group #	ID #
Name of Insured		Insureds Soc. Sec. #	Relationship to Patient
			Co-Pay Amount
Name of Secondary Insurance Company		Group #	ID #
Name of Insured		Insureds Soc. Sec. #	Relationship to Patient
			Co-Pay Amount

### EMERGENCY INFORMATION

Emergency Contact		Relationship to Patient	
Address		Home Phone	Other Phone
		( ) -	( ) -

### MEDICAL INFORMATION

Are you allergic to any medications?	If yes, please list names
<input type="checkbox"/> Yes <input type="checkbox"/> No	

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, including Medicare, private insurance and other health plans, to this practice. I understand it is my responsibility to pay any deductible or co-insurance amount, and that I am financially responsible for all charges whether or not paid by said insurance. Finally, I will be responsible for any charges incurred due to non-notification of required insurance information necessary to process my health insurance claims.

**SIGNATURE:**

**DATE:**

**OB/GYN ASSOCIATES, P.A.  
HEALTH HISTORY**

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE \_\_\_\_\_

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

Today's date \_\_\_\_\_ When was your last physical exam? \_\_\_\_\_ Last Period: \_\_\_\_\_

1. **VITALS:** Height: \_\_\_\_ ft \_\_\_\_ in Weight: \_\_\_\_ lbs (**Staff use:** Temp: \_\_\_\_ RR: \_\_\_\_ Pulse: \_\_\_\_ )

2. **PAST MEDICAL HISTORY** - Have you ever had the following: \_\_\_\_\_ **Patient denies any PMH**

Dates	Dates	Dates
____ Last Pap Smear _____	____ Last Mammo _____	____ Last Colonoscopy _____
____ Last Bone Density Scan _____	____ Cancers _____	Type: _____
____ Heart Disease _____	____ Uterine fibroids _____	____ Thyroid Disease _____
____ Diabetes _____	____ Abnormal Pap _____	____ Anxiety/Depression _____
____ Hepatitis _____	____ Gastric disorder _____	____ High Cholesterol _____
____ Anemia _____	____ Arthritis _____	____ Asthma _____
____ Hypertension _____	____ Bone Fractures _____	____ Headaches _____
____ Sickle Cell _____	____ Osteoporosis _____	____ Urinary Incontinence//UTI _____
____ Blood Transfusions _____	____ Endometriosis _____	____ Kidney Problem _____
____ Seizures _____	____ Infertility _____	____ Abnormal Mammogram _____
____ Trauma or Abuse _____	____ Sexually Transmitted Dis: Gonorrhea, Chlamydia, HPV, Genital Herpes, Syphilis	

3. **PAST SURGICAL HISTORY** - Have you ever had the following \_\_\_\_\_ **Patient denies any surgeries**

Please list all serious illnesses, operations & other hospitalizations you have experienced and indicate year these occurred

Hysterectomy \_\_\_\_\_ C-Section \_\_\_\_\_ D&C \_\_\_\_\_ Abdominal \_\_\_\_\_  
 Appendix \_\_\_\_\_ Gallbladder \_\_\_\_\_ Breast Biopsy \_\_\_\_\_ Tonsils \_\_\_\_\_ Bladder \_\_\_\_\_  
 \_\_\_\_\_ Cosmetic \_\_\_\_\_ Breast Implants Reduction \_\_\_\_\_  
 Tubal Ligation \_\_\_\_\_ Wisdom Teeth \_\_\_\_\_ Other \_\_\_\_\_

4. **MEDICATIONS:** Please list all **medicines** you are currently taking  please continue on back of sheet

\_\_\_\_ **Patient denies taking any Medications**

CURRENT MEDICATIONS:	DOSAGE (mg)	how often per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Please list all **ALLERGIES** (food, drugs, and environment) \_\_\_\_\_ **Patient denies any Allergies**

\_\_\_\_\_  
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8. Reason for today's visit-

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**9. REVIEW OF SYSTEMS:**

**DO YOU HAVE NOW OR HAVE YOU HAD ANY OF THE BELOW PROBLEM WITHIN THE PAST YEAR:**

(Please circle anything for which you have a history of)

- Constitutional:** fever, stress, weight change, fatigue, Insomnia
- Eyes:** change/ vision, blurred vision, double vision
- HENT:** sinus pain, headaches, sore throat, ear ache, lightheadedness,  
head injury, ear aches, nose bleeding, frequent colds
- Breast:** nipple discharge/pain, lumps/mass, asymmetry, redness
- Cardiovascular:** chest pain, irregular heartbeats, cold extremities, Numbness, swelling  
shortness of breath with exertion
- Respiratory:** coughing, shortness of breath, spitting up blood, Asthma/wheezing
- Gastrointestinal:** diarrhea, Loss of Appetite, nausea/vomiting, change in bowel  
constipation, blood in stool
- Genitourinary:** urgency, frequency, painful urination, night time frequency  
leakage of urine with coughing, sneezing or exertion
- Integument (Skin):** rash, itching, new skin lesions, Jaundice (yellowish)
- Neurological:** seizure, tremors, tingling or numbness, change in speech
- Musculoskeletal:** back pain, joint pain, muscle pain, swelling
- Endocrine:** frequent urination, excessive thirst, cold/heat intolerance,
- Psychiatric:** anxiety, depression, memory loss, confusion

**Date:** \_\_\_\_\_ **Signature of Patient/ Parent if minor:** \_\_\_\_\_



**FINANCIAL POLICY**

Thank you for choosing our practice. Our office is committed to providing the best possible treatment and also in assisting you with insurance filing and payment of your account. In order to accomplish this in a cost effective manner, we ask that you adhere to the guidelines listed below.

1. We will file a claim to your insurance carrier if we are given complete demographic and insurance information. If information is incomplete, we will require payment in full of your charges the day of your visit.
2. Co-payments are due at the time of service. A \$10.00 service fee will be assessed for failure to pay a co-payment when you checkout.
3. Since we are unaware of each insurance plans specific benefits and which of our services are covered by your plan, we will not be held responsible for unpaid amounts as a result of denials from your insurance company due to non-covered service clauses.
4. Most laboratory charges ordered through our office are billed separately to your insurance by either Lab Corp, Quest Diagnostics, or Phyttest, our lab billing service. If you receive a bill from one of these companies, we ask that you contact them to resolve any question you may have.
5. We realize that OB patient's insurance plans may change over the course of the pregnancy term. We require that the patient keep us updated on those changes. Failure to provide updated information in an expedient manner may result in timeliness denials from your insurance carrier which the patient will ultimately be held responsible for.
6. All OB patients are required to pay at least 50% of the portion of the delivery fee not covered by insurance by the 1<sup>st</sup> day of the 4<sup>th</sup> month of pregnancy. The remaining 50% is due by the 1<sup>st</sup> day of the 6<sup>th</sup> month. OB patients are also required to promptly pay for any other services provided during the pregnancy. Care may be discontinued at any time for noncompliance of the above.
7. Account balances that have not been paid within 60 days will be charged a finance charge of \$3.00 or interest of 1<sup>1</sup>/<sub>2</sub>% per month (whichever is greater).
8. We expect you to call at least 24 hours in advance in the event you cannot make an appointment. A \$25.00 fee will be assessed for all no shows.

*I have read and received a copy of the Payment Policy. I accept this policy for treatment with OB-GYN Associates.*

Patient Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_

OB-GYN ASSOCIATES, P.A.

699 Church Street, Suite 300  
Marietta, GA 30060

**PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

As Required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

A copy of the Notice of Privacy Practices of OB-GYN Associates, P.A. is posted in the lobby for my review. I am aware that I can obtain a copy of this Notice at any time.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the main waiting room area of OB-GYN Associates, P.A.

I also understand that if I have any questions with regard to this Notice of Privacy Practices, I may contact in writing the Practice Administrator at the following address:

OB-GYN Associates, P.A.  
699 Church Street, Suite 300  
Marietta, Georgia 30060  
770 425-7601 (Fax)  
[pmclinden@ogamarietta.com](mailto:pmclinden@ogamarietta.com) (email)

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Signature of Patient

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Print Name

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Date

**OB-GYN ASSOCIATES, P.A.**

MEDICAL INFORMATION RELEASE

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

MEDICAL INFORMATION AND/OR TEST RESULTS MAY BE:

- GIVEN TO **PATIENT ONLY**
- GIVEN TO THE FOLLOWING PERSON(S)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MESSAGES:

- MAY BE LEFT ON HOME ANSWERING MACHINE
- MAY BE LEFT ON WORK VOICEMAIL
- DO NOT LEAVE MESSAGE AT WORK OF HOME

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date