

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-

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 1st day of the 4th month of pregnancy. The remaining 50% is due by the 1st day of the 6th 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 1¹/₂% 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 (email)

Signature of Patient

Print Name

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

OB-GYN ASSOCIATES, P.A.
FAMILY QUESTIONNAIRE



Name: _____

Date _____

1. Will you be 35 years or older when the baby is due? Yes No
2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders:
 - Down Syndrome (mongolism)? Yes No
 - Other chromosomal abnormality? Yes No
 - Neural tube defect, spina bifida (meningomyelocele or open spine), anencephaly? Yes No
 - Hemophilia? Yes No
 - Muscular dystrophy? Yes No
 - Cystic fibrosis? Yes NoIf yes, indicate the relationship of the affected person to you or to the baby's father. _____
3. Do you or the baby's father have a birth defect? Yes No
If yes, who has the defect and what is it? _____
4. In any previous marriages, have you or the baby's father had a child born dead or alive with a birth defect not listed in question 2 above? Yes No
If yes, what was the defect and who had it? _____
5. Do you or the baby's father have any close relatives with mental retardation? Yes No
If yes, indicate the relationship of the affected person to you or to the baby's father
Indicate the cause, if known: _____
6. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal abnormality not listed above? Yes No
If yes, indicate the condition and the relationship of the affected person to you or to the baby's father.

7. In any previous marriages, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses? Yes No
Have either of you had a chromosomal study? Yes No
If yes, indicate who had the results: _____
8. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sach's disease? Yes No
If yes, indicate who and the results: _____
9. If you or the baby's father are black, have either of you been screened for sickle cell trait? .. Yes No
If yes, indicate who and the results: _____
10. If you or the baby's father is of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalassemia? Yes No
If yes, indicate who and the results: _____
11. If you or the baby's father is of Philippine or Southeast Asian ancestry, have either of you been tested for a-thalassemia? Yes No
If yes, indicate who and the results: _____
12. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? (include nonprescription drugs) Yes No
If yes, give the name of medication and time taken during pregnancy: _____

Patient Signature: _____

Reviewed by: _____ M.D.

OB-GYN ASSOCIATES, PA

699 Church Street, Suite 300

Marietta, GA 30060

TO OUR PATIENTS WITH MEDICAID COVERAGE

This communication is to notify you that our group considers Georgia Health Partnership (Medicaid) and all its contracted CMO plans (Amerigroup, Wellcare and Peachstate) to be a choice of last resort for payment of your obstetrical care. Any primary insurance carrier (i.e., Aetna, Blue Cross, United Healthcare, etc.) must be billed first according to the laws of this State, even if that coverage does not include maternity benefits.

If you knowingly do not inform Medicaid and us that you have another health insurance policy, you are committing insurance fraud. This is an illegal act that is prosecutable by law. If you have another insurance plan at this time or at any time during your pregnancy, you are required to provide us with that information.

If Medicaid pays your claims and then later demands their payment back due to another policy being the primary coverage at the date of service, you will be responsible for remitting to us the balance in full. If immediate full payment is not received, we reserve the right to commence prosecution as dictated by State law.

Please choose an option and sign below to acknowledge receipt of this notice.

I, _____, do not have any other medical insurance coverage other than Georgia Medicaid or a contracted CMO.

I, _____, do have other insurance and would like to provide it to you at this time.

Signed: _____

Date: _____

OB/GYN ASSOCIATES, P.A.
699 CHURCH STREET, SUITE 300
MARIETTA, GA 30060

To our patients with Medicaid benefits,

Have you chosen your C.M.O. (Care Managed Organization) yet? You need to do so within the first 60 days of your coverage. If you do not, Medicaid will automatically assign you to a plan and it may be a plan we do not take. Should this occur, you would be asked to change groups immediately.

Your choices are Amerigroup, Wellcare, and Peach State Insurance plans. **We do not accept Peach State**, so please do not choose this plan. **We recommend Amerigroup** as they do not have any limitations on how many ultrasounds you may have within your pregnancy. All you need to do is call Georgia Healthy Families at (888) 423-6765 and request they add you to one of the above C.M.O plans. Please do not choose us as your P.C.P (primary care provider) as we are a specialty physician group.

If you have any questions, please contact me at (770) 422-8700 ext. 4131

We wish you a healthy pregnancy.

Anje Clayton
OB & GYN Billing Coordinator