Maternal Gynerations
The leader in fertility, obstetric and gynecology care

761 Old Norcross Road, Lawrenceville, GA 30046 • Phone: (770) 513-4000 • Fax: (770) 995-3495
www.maternalgynerations.net

PATIENT ACCOUNT #_____ Referred by: _____

Preferred Pharmacy, Address, Phone Number & City_____

Your Name: _____
Last *First* *Middle*

Preferred Name: _____ Primary Language: _____

Date of Birth: _____ SSN: _____

Race: ❑ American Ind./Alaska Native ❑ Asian ❑ Black/African American ❑ Nat Hawaiian/Pacific Islander ❑ White ❑ Other Race ❑ Declined

Ethnicity: (MUST COMPLETE) ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined Marital Status: S M D W

Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Home # _____ Work# _____ Cell # _____

Email: _____ Employer: _____

Preferred Communication for Appointment Reminders: ❑ Email ❑ Phone ❑ Text ❑ Other _____

Emergency Contact: _____ Relationship: _____ Phone Number:_____

Is your insurance through (please check all that apply): ❑ My Employer ❑ Private ❑ Spouse ❑ Parent

Insurance Co. Name: _____

Full Name of Insured: _____

Date of Birth: _____ Social Security Number: _____

It is the policy of this office to pay for services in full when rendered except in cases of pregnancy or surgery. If this applies to you, we will file your claim and you will be expected to pay only what the insurance does not pay. You must have your current insurance card at time of service or you will be expected to pay in full. Return check fee is $30. A no show fee of $25-50 will be billed if appointment is not cancelled within 24 hours. Insurance is not a guarantee of payment. It is your responsibility to confirm your benefits.

In case any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein incurred. If this account is placed with a collection agency, the undersigned parties agree to pay all fees for cost of collections.

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information for the processing of this claim. I understand that my prescription will be sent, and my medication information, including formulary benefits, may be obtained through MatGyn electronic prescribing function.

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____

HIPAA PRIVACY RULE: Please list the parties that you authorize Maternal Gynerations, P.C. to disclose your protected health information (PHI). **MUST BE FILLED OUT BY PATIENT ONLY** (If this form is completed electronically via the Patient Portal, then you will be asked to initial this HIPPA Authorization when you come in to the office.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I HAVE RECEIVED/READ A COPY OF MATERNAL GYNERATIONS. P.C. NOTICE OF PRIVACY PRACTICES.

PATIENT'S INITIALS _____

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MATERNAL GYNERATIONS-PROBLEM VISIT

Name	Date of Last Period:	Date
Name Preferred to be called	Birth date	Age
Reason for visit: Describe problem		

PLEASE LIST ALL MEDICATION/SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING:

Drug name and dosage	Physician	List all "natural" or herbal remedies, over the counter drugs, vitamins or minerals you are taking.

Allergies To Medications, Latex Gloves, Etc? □No □Yes	What are you allergic to and what was the reaction you had?

YOUR GYN HISTORY

How many days are there from the start of one period to the start of your next period?	
How long does your period last? _____days.	Flow: □ Light □ Medium □ Heavy Clots □ Yes □ No
Date of last menstrual period:	Are you certain of that date? □Yes □No
Have you gone thru menopause? □ No □ Yes	If yes when:
Are you using hormone replacement therapy (hormones)? □ Yes □ No	
Do you use birth control? □ No □ Yes If yes circle which one:	

Birth Control Pill (which one)	On average, how many pills do you miss/skip a month?	
Birth Control Patch	Diaphragm	Nuvaring
Condoms	Implanon	Tubal Ligation/Essure
Contraceptive Foam/Jelly	IUD: Mirena/Paraguard Date inserted:	Vasectomy
Depo-Provera (shot)	Natural Family Planning/Rhythm	Withdrawal

Do you have cramps with your period? □No □ Mild □ Moderate □ Severe
Do you have pelvic pain at other times? □ Yes □ No If yes when:
Do you have bleeding between periods? □ Yes □ No If yes when:
Tobacco Use: □ Never □ Former □ Current How Much? _____

YOUR SOCIAL HISTORY

New sexual partner? □ Yes □ No How long have you been with your current sexual partner? _____
Marital Status □ Single □ Married □ Widowed □ Divorced □ Separated □ Engaged
Are you sexually active? □ Yes □ No
Do you have sex with □ Husband □ Men □ Women □ Both
Are you taking any new medications since your last visit?
Review of Systems:
Please circle if any of the following apply to you NOW.
Constitutional: Fatigue Fever Hot flashes Weight Loss Weight Gain
HENT: Headaches Lightheadedness Nose Bleeds Sinus Pain Thyroid Mass Sore Throat
BREAST: Lumps Tenderness Swelling Nipple Discharge

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GASTROINTESTINAL: Nausea Vomiting Diarrhea Constipation Abdominal Pain Blood in stools

GENITOURINARY: Urgency Frequency Painful urination Nighttime urination
Blood in urine Leaking urine Decreased sex drive Painful intercourse
Genital Sores

SKIN: Rash itching Dry skin New lesions or moles Acne

ENDOCRINE: Loss of Hair Cold intolerance Heat intolerance

PSYCHIATRIC: Anxiety Depression Compulsive Behavior Impulsive Behavior
Suicide thoughts Excess anger Mood swings

HEMOTOLOGICAL/LYMPHATIC: Easy bruising Lymph node enlargement