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 ________

761 Old Norcross Road, Lawrenceville, GA 30046 • Phone: (770) 513-4000 • Fax: (770) 995-3495
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Willard C. Hearin, MD
Renwick C. Hood, MD
Lance J. Wiist, MD
Andrew T. Doris, MD
Brittainy Dark, MD
John T. Hydrick, MD
Edmund S. Kim, MD
Melanie E. Watkins, MD
Rebecca L. Williams, MD
Jonne J. Sveum, APRN, CNM
Kristine E. Miller, APRN, WHNP
Vicki Roebuck, MS, APRN, WHNP
Ashley Grimes, APRN, WHNP

PAIN MEDICINE POLICY

Please read carefully and sign at the bottom. A copy will be provided to you upon request.

1. I agree to take narcotic medication exactly as instructed. I am NOT allowed to change dosage amounts or alter the time schedule of taking the medication without first talking to my prescribing physician.
2. Narcotics will NOT be phoned in after business hours or on weekends.
3. Only one pharmacy will be used for filling narcotic prescriptions.
4. The following are conditions for immediate termination from the practice.
    a. Obtaining narcotics from any other physician while under our care without our knowledge.
    b. Altering or forging of a prescription is a felony and will be reported.
5. Patients may be terminated from the practice with 30 days notice for noncompliance in the taking of their medication.
6. We will NOT refill prescriptions that have been lost or misplaced. Please be responsible in keeping up with your narcotic prescriptions.
7. Stolen medications will be replaced ONE time only if you have a valid police report.
8. In the case of intolerance or ineffective narcotic medications, a different prescription could be given, provided the unused portion of the previously prescribed medication was returned.
9. I am aware that most of the manufacturers of drugs used to treat chronic pain recommend AGAINST the operation of heavy equipment, which include driving a motor vehicle. I am aware that if I choose to drive a vehicle I could be charged with a DUI.
10. I have been given information about the use of narcotic medications, including but not limited to, possible risks and adverse side effects such as the development of tolerance, dependence, addiction, withdrawal, constipation, nausea, itching, harmful effects to an unborn child, urinary retention, impairment of reasoning and judgment, and depression of breathing.
11. I will not combine any narcotic medications with the consumption of alcohol.
12. I will not give, trade or sell pain medications.
13. I will allow 24 hours for a prescription refill to be authorized. I also understand that requests received after 3:00 PM are handled on the next business day.
14. Only one pharmacy may be used for filling prescriptions. My pharmacy's name and location is:

    ____

Pharmacy's Phone Number: ____

I have read and understand the above policy and agree to abide by its terms.

Patient Signature ____________________________________ Date _____________________

Print Name ____ Date of Birth _______________

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MATERNAL GYNERATIONS-NEW GYN

Name	Last Menstrual Period:	Date
Name Preferred to be called	Birthdate	Age
Referred by		
Reason for visit: □ Routine Physical □ Problem	Describe problem:	

YOUR MEDICAL HISTORY NONE ( )

Check if you have now or have ever had ANY of these in the past and when or at what age:

Major Illnesses	YES/WHEN	Major Illnesses	YES/WHEN
Alcohol # per day/wk		HIV/AIDS	
Anemia		Human Papilloma Virus/HPV	
Anxiety		Hyperthyroid	
Asthma		Hypothyroid	
Bipolar disorder		Irritable Bowel Syndrome	
Blood transfusion, why		Kidney Infection (not bladder or UTI)	
Breast Cancer		Kidney Stones	
Cancer, what type		Lupus	
Chickenpox		Migraine Headaches	
Chlamydia		MRSA	
Depression		Osteoporosis/Osteopenia	
Diabetes		Pap smear abnormal	
Drug use, drug and amount used		Pulmonary Embolus/DVT	
Eating disorder and type		Rheumatoid arthritis	
Glaucoma		Seizure disorder	
Gonorrhea		Stroke	
Heart Disease		Syphilis	
Hepatitis/Liver Disease		TB-Tuberculosis	
Herpes/HSV		Tobacco use, amount per day	
High Cholesterol		Ulcers	
High Blood pressure		UTI/bladder infection more than 2X/year	

Do you have any other problems we have not asked you about which you feel may be important?

Please list ALL hospitalizations and or surgeries you have had. List reason and dates. NONE ( )

Date	Surgery/Hospitalization/Reason	Date	Surgery/Hospitalization/Reason

PLEASE LIST ALL MEDICATION/SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING: NONE ( )

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?

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FAMILY HISTORY NONE ( )

Check the problems that your blood relatives have had and list the affected family member. Use the following abbreviations: M-Mother; F-Father; B-Brother; S-Sister; MGM-mom's mom; MGF-mom's dad; PGM-dad's mom; PGF-dad's father; A-Aunt; U-Uncle

Disease	Who	Disease	Who
Alzheimer's		Hepatitis/Liver disease	
Bowel Disorder (type)		High Cholesterol	
Breast Cancer		High Blood Pressure	
Cancer (what type)		Osteoporosis	
Colon polyps or colon cancer		Pulmonary embolism/DVT	
Depression/Mood disorder (type?)		Stroke	
Diabetes		Thyroid disease	
Heart disease (type)		Other:	

YOUR GYN HISTORY

What age did you have your first period?

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:

Have you had any Gardisil vaccinations? □ Yes □ No,If yes how many (this is a series of 3 vaccinations) 1 2 3

YOUR OB HISTORY

Total # of pregnancies	Full term births
Premature deliveries (less than 37 weeks)	Abortions/terminations
Miscarriages	Living Children

On the chart below please fill in the answers for each pregnancy including abortions or miscarriages

If you have had a tubal ligation, hysterectomy or are postmenopausal you may skip to the next section.

No.	Birth	Wks	Labor	Baby Wt/Sex	Del type	Epid	Preterm	Wt	Comments/Complications	Hospital
1										
2										
3										
4										
5										

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YOUR SOCIAL HISTORY

History of Abuse □ No □ Physical □ Emotional □ Sexual Did you receive counseling? □ Yes □ No

Age at first intercourse: _________

Do you do self breast exams □ Yes □ No

Do you take calcium □ Yes □ No Name and dosage

Education: □ Did not finish HS □GED □ High School □ High School + some college □ College degree

Do you exercise? □ No □ Yes _____ days a week

Lifetime sexual partners: □ Husband/one partner only □ Less than 5 □ 5 or more

New sexual partner? □ Yes □ No How long? ___________

Marital Status □ Single □ Married □ Widowed □ Divorced □ Separated □ Engaged

Do you drink milk or eat dairy products □ Yes □ No Servings per day ______

Are there any religious or cultural preferences that would affect your care? □ Yes □ No What:

Do you use seat belts □ Yes □ No

Are you sexually active? □ Yes □ No

Do you have sex with □ Husband □ Men □ Women □ Both

Occupation:

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

CARDIOVASCULAR: Chest pain Irregular Heart Rate Rapid Heartbeat Fainting Swelling of legs Varicose Veins

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

What are some of the questions you would like answered today?

When are you planning to have another child: (please check one)

□ Within the next year □ Within the next five years

□ Within the next 10 years □ My family is complete

Would you like information on a gentle, hormone free permanent birth control procedure performed in the comfort of our office? □ Yes □ No

Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods? □ Yes □ No