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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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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Name		Date
Name Preferred to be called	Birth date	Age
Referred by		

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:	

GENETIC SCREENING

If you, the father of the baby, or any blood relative have had any of the following please indicate who:

Autism		Neural tube defect, spina bifida, anencephaly, menigomyelocele	
Cystic fibrosis			
Down Syndrome		PKU	
Fragile X		Recurrent pregnancy loss or stillbirth	
Heart defect at birth and type		Sickle cell disease or trait	
Hemophilia		Used any medications, drugs, alcohol or tobacco since your last period?	
Huntington chorea or disease			
Inherited genetic/chromosomal disorder		Tay Sachs disease	
Mental Retardation		Thalassemia	
Muscular dystrophy		Any other birth defects not listed above	

Mothers Race: □ White □ African American □ Hispanic □ Asian □ Other

Father of the baby's Race: □ White □ African American □ Hispanic □ Asian □ 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

Were you using any birth control when you got pregnant? □ 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	Tubal/Essure
Condoms	IUD: Mirena/Paraguard Date inserted:	Vasectomy
Contraceptive Foam/Jelly	Natural Family Planning/Rhythm	Withdrawal
Depo-Provera (shot)	NuvaRing	Other:

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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		
6		

YOUR SOCIAL HISTORY	
History of Abuse □ No □ Physical □ Emotional □ Sexual Did you receive counseling? □ Yes □ No	
Do you do self breast exams □ Yes □ No	Do you plan to breastfeed your baby? □ Yes □ No
Do you take calcium □ Yes □ No Name and dosage	
Do you have an infant car seat? □ Yes □ No	
Do you have a cat? □ Yes □ No	Do you clean the litter box? □ Yes □ No
If you've had a Cesarean Section, do you want a repeat Cesarean Section? □ NA □ Yes □ No	
Do you plan to take childbirth classes? □ Yes □ No	
If you have a son do you want him circumcised? □ Yes □ No	
What do you plan to use for contraception after the birth of this baby?	
Education: □ Did not finish HS □ GED □ High School □ High School + some college □ College degree	
Do you plan to have an epidural for labor? □ Yes □ No	
Do you exercise? □ No □ Yes _____ days a week	
Is the father of this baby involved in this pregnancy? □ Yes □ No Father of Baby's Name:	
Lifetime sexual partners: □ Husband/one partner only □ Less than 5 □ 5 or more	
New sexual partner? □ No □ Yes How long? _____	
Marital Status □ Single □ Married □ Widowed □ Divorced □ Separated □ Engaged	
Do you drink milk or eat dairy products □ No □ Yes Servings per day _____	
Do you have a pediatrician? □ No □ Yes Who?	
Do you want your tubes tied after the birth of this baby? □ Yes □ No	
Are there any religious or cultural preferences that would affect your care? □ No □ Yes What:	
Do you use seat belts □ Yes □ No	
Are you sexually active? □ Yes □ No	
Do you have sex with □ Husband □ Men □ Women □ Both	
Are you planning any out of town trips during this pregnancy? □ Yes □ No	
What was your pre-pregnant weight?	
Review of Systems:	
Please circle if any of the following apply to you NOW.	

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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?