Patient Registration Form

Date of Appointment: ____________________

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth (Age)	Social Security Number		
Patient's Address		City		State	Zip
Home Phone		Mobile Phone	Email Address		
Referred by		Primary Care Physician	Primary Care Physician Phone		
Pharmacy	Pharmacy Phone	Pharmacy Address			

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone	
Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan		
Plan Number	Group Number	Insured's Employer/School		
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number	
Insured's Address		City	State	Zip
Insured's Social Security Number	Insured's Birthdate			

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient	
Address	City	State	Zip

_______________________________ Signature of Patient or Authorized Guardian

_______________________________ Date

Date of Appointment: ____________

Name ____________ Gender ______ Age ______

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism ☐ Allergies ☐ Anemia ☐ Anxiety Disorder ☐ Arthritis ☐ Asthma ☐ AIDS / HIV
☐ Back Problems ☐ Bleeding Disorder ☐ Blood Disease ☐ Blood Transfusion ☐ Cancer ☐ Diabetes ☐ Depression
☐ Ear Problems ☐ Eating Disorder ☐ Epilepsy ☐ Glaucoma ☐ Gout ☐ Heart Disease ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ High Blood Pressure ☐ High Cholesterol ☐ Joint Disorder ☐ Kidney Disorder ☐ Liver Disorder ☐ Lung Disease
☐ Measles ☐ Migraines ☐ Osteoporosis ☐ Pneumonia ☐ Polio ☐ Rheumatic Fever ☐ Stroke
☐ Skin Disorder ☐ Stomach Ulcer ☐ Substance Abuse ☐ Thyroid Disorder ☐ Tuberculosis ☐ Venereal Disease

Hospitalizations & Surgeries

Reason	Date

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Allergies ☐ Alzheimer's ☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ AIDS/HIV ☐ Bleeding Disorder ☐ Blood Disorder
☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Disorder ☐ Glaucoma ☐ Heart Disease ☐ Hepatitis ☐ High Cholesterol ☐ High Blood Pressure
☐ Joint Disorder ☐ Kidney Disease ☐ Liver Disorder ☐ Lung Disease ☐ Migraines ☐ Psychiatric Disorders ☐ Osteoporosis ☐ Stroke ☐ Substance Abuse ☐ Thyroid Disorder

Details: ____________

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year ______

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years ______ # packs/day ______

Do you smoke now?

☐ Yes ☐ No # packs/day ______

Do you use recreational drugs?

☐ Yes ☐ No types? ______ # times/week ______

How much alcohol do you drink per week?

drinks/week ______

How much caffeine do you drink per day?

drinks/day ______

How often do you exercise?

times/week ______

Date of Appointment: ____________

Name ____________ Gender ______ Age ______

OBGYN History

Have you ever had or do you currently have any of the following?

- [ ] Abnormal Vaginal Bleeding
- [ ] Abnormal Pap Smear
- [ ] Bleeding between Periods
- [ ] Breast Lump
- [ ] Breast Cancer
- [ ] Breast Surgery
- [ ] Cervical Cancer
- [ ] Chlamydia
- [ ] Colposcopy
- [ ] Cryosurgery
- [ ] DES Exposure
- [ ] Extreme Menstrual Pain
- [ ] Fibroids
- [ ] Genital Warts
- [ ] Gonorrhea
- [ ] Herpes
- [ ] Hot Flashes
- [ ] HPV
- [ ] Infertility
- [ ] Irregular Periods/Bleeding
- [ ] Nipple Discharge
- [ ] Ovarian Cysts
- [ ] Ovarian Cancer
- [ ] Painful Intercourse
- [ ] Pelvic Inflammatory Disease
- [ ] Uterine Cancer
- [ ] Urinary Incontinence
- [ ] Yeast Infections – Frequent

Pregnancy History

Please describe any pregancies you have had.

# of Pregnancies ______ # of Full Term ______ # of Miscarriages ______ # of Abortions ______

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living

Were there any complications associated with any of your pregnancies?

____

Are you currently pregnant?

- [ ] Yes - [ ] No

Are you trying to become pregnant?

- [ ] Yes - [ ] No

Do you need birth control or contraceptive advice?

- [ ] Yes - [ ] No

What method of birth control do you use?

____

Menstrual History

When was the first day of your last period?

____

How often does your period occur?

____

How long does your period last?

____

Is your period regular?

- [ ] Yes - [ ] No

What age were you when you had your first period?

____

What age where you at menopause?

____

Health Exams & Procedures

Please check and date all immunizations you have had.

	Month & Year	Results
[ ] Blood Sugar-Fasting		
[ ] Breast Self Exam		
[ ] Cholesterol Test		
[ ] Colonoscopy		
[ ] CT/CAT Scan		
[ ] Dexascan (Bone Density)		
[ ] EKG		
[ ] Echocardiogram		
[ ] Fecal Occult Blood Test		
[ ] Mammogram		
[ ] MRI		
[ ] Pap Smear		
[ ] Physical Exam		
[ ] Cardiac Stress Test		
[ ] Ultrasound		

OB/GYN SPECIALISTS OF COLUMBUS, P.C.
RUTHANN F. REES, M.D., PH.D.

FINANCIAL POLICY

Patient Name (please print) ______________________________ **Date of Birth:**____________

Thank you for choosing OB/Gyn Specialists of Columbus as your obstetrics and gynecology provider. We are committed to providing you with quality and affordable health care and ensuring that your treatment is successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Payment Policy and explains your financial responsibilities. Please read it, let us know if you have any questions, and sign below.

All patients must complete our "Patient Information Form" prior to seeing the doctor.

1) **Co-payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. We accept cash, checks and Visa/Mastercard. If your referring physician has indicated an alternative payment plan please take the time to notify the business office representative. This will greatly alleviate any potential confusion, and ensure that your account remains current. ***Please Initial:***________

2) **Insurance.** If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits. If your insurance does not pay your claim within 45 days, the balance will be your responsibility. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. For those with two or more private insurance plans, we will bill only your primary and secondary insurer. ***Please Initial:***________

3) ***I request that payment of authorized Medicare and/or other insurance company benefits be made to OB/Gyn Specialists of Columbus on my behalf for any services furnished to me by OB/Gyn Specialists of Columbus. I authorize any holder of medical information about me to release any information needed to determine those benefits to pay for related services.** ***Please Initial:***________

4) **PPOs.** We are enrolled in various PPO programs; please check your insurance provider booklet to see if we are members of your specific plan. If we are not, you will be responsible for the balance not covered by your insurance plan, regardless of the insurance company's determination of usual and customary rates. If we are members, you will only be responsible for non-covered services, co-payments and deductibles. ***Please Initial:***________

5) **Medicare.** Our medical group accepts Medicare assignments. This means that you will be responsible for co-payments and deductible, and that the difference between what we charge and what Medicare approves will be written off. In the event that you have a secondary carrier, you will only be responsible for the deductible if your secondary carrier does not pay the Medicare deductible. Recent Federal Legislation has made it illegal for physicians to routinely write off co-payments and deductibles. ***Please Initial:***________

6) **Advance Beneficiary Notice or Waiver of Liability.** Medicare or your insurance may not pay for all your healthcare services. The fact that they will not pay for a particular service does not mean that it is not medically indicated. There is good reason why your physician recommended it. You will be informed on how much these services may cost and be asked to sign the waiver of liability forms. ***Please Initial:***________

7) **Claim submission.** We cannot bill your insurance unless you bring in all insurance information. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. We are not party to that contract.

Please Initial:________

OB/GYN SPECIALISTS OF COLUMBUS, P.C.
RUTHANN F. REES, M.D., PH.D.

8) **Insurance Cards.** Photocopies of the front and back of all insurance cards must be maintained in our business office at all times. If you see the doctor and do not provide us with complete insurance information, your account will be assigned a cash status, and payment in full will be required at the time of the visit. ***Please Initial:________***

9) **Authorization to release information.** OB/Gyn Specialists of Columbus physicians and staff may give out written or verbal information concerning my medical records to any insurance carrier or agent that is authorized to have access to and make copies of my medical records. ***Please Initial:________***

10) **Self Pay.** Self pay patients are required to pay 100% fee for service at time of visit. Our staff will gladly give you an estimate of your visit prior to your appointment. The estimate given is for our office only and does **NOT** include any labs/testing that is sent to PathGroup. They will send you a separate bill. ***Please Initial:________***

11) **Nonpayment.** If your account is over 60 days past due, you will receive a letter stating you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collections agency. Should the account be referred to an attorney or collection agency, the undersigned agrees to pay the actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate. ***Please Initial:________***

12) **Missed appointments.** It is important to give us at least 24 hours notice if you will not be able to make an appointment. You will be charged if cancellation does not occur within 24 hours (weekday) of your appointment. Office Visits, Consults and ultrasounds **$75** / Special Procedures **$100**. All hospital surgery procedures will be charged at a rate of **$350.** If not given a 2 week notice. ***Please Initial:________***

13) **Special letters and Healthcare related form completion.** Any requests for a letter describing any medical conditions and/or treatments will be charged at a rate of $50 ***Please Initial:________***

14) **Copy of medical records.** Any request for copy of medical records is $35. ***Please Initial:________***

ACKNOWLEDGEMENT OF RECEIPT OF
OB/GYN SPECIALISTS OF COLUMBUS NOTICE OF FINANCIAL POLICIES

By signing this document, I acknowledge that I understand and agree with OB/Gyn Specialists of Columbus Financial Policies

*Name (printed):*______________________________ *Date:*______________

*Signature:*____

Ruthann F. Rees, M.D., Ph.D., FACOG

APPROVAL OF ACCESS TO HEALTHCARE INFORMATION

Patient Name: ____

Maiden Name: ____

DOB: ______________________________ SSN: ____________________________

I request and approve that the following person(s) be given access to healthcare information as is specified below:

______________________________ Relationship: ____________________

______________________________ Relationship: ____________________

______________________________ Relationship: ____________________

Please check all that apply:

___ The ability to schedule and cancel appointments on my behalf.

___ Full access to test results* (including labs, diagnostic imaging, etc.)

___ My entire chart*.

*I understand that this information may include reference to or treatment of drug and alcohol abuse, psychological illness, or test results for HIV/AIDS.

Patient's Signature: ____

Date: ______________________________ Expiration: ____________________________

1604 12TH Street, Columbus, GA 31906
Phone: 706-324-0471 Fax: 706-324-0473
www.obgynsoc.com

Risk Assessment for Hereditary Cancers

Patient Name: ______________________ Provider: ______________________

Date of Birth: ______________________ Today's Date: ______________________

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY - BOTH MOM AND DAD'S SIDE OF THE FAMILY. Include any of the below family members:

Yourself Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather First Cousin

If you do not know the exact age of diagnosis for your family member, you may enter a best guess or a decade. For example, "40s" or "60s"

		YOU?	Which Family Member?	Mom's side or Dad's side?	Age at diagnosis
Y N	Breast cancer before age 50	______	______	______	______
Y N	3 or more breast cancers on	______	______	______	______
	the same side of the family	______	______	______	______
		______	______	______	______
Y N	Breast cancer in both breasts or breast cancer twice in same person	______	______	______	______
Y N	Male breast cancer	______	______	______	______
Y N	Ovarian cancer	______	______	______	______
Y N	Colorectal cancer before age 50	______	______	______	______
Y N	Endometrial (Uterine) cancer before age 50	______	______	______	______
Y N	3 or more Colon, Endometrial,	______	______	______	______
	Ovarian, Brain, Gastric, Pancreatic,	______	______	______	______
	Small Bowel, Renal/Pelvic cancers	______	______	______	______
	on the same side of the family				

Y N Ashkenazi Jewish ancestry with a family member with breast, ovarian, or pancreatic cancer at any age?

Y N Have YOU ever had endometrial (uterine) cancer, regardless of age of diagnosis? List age: ______

Y N Have you or any member of your family ever been tested for BRAC or Lynch Syndrome?
If yes, please explain: ______________________

____

Patient's Signature Date

FOR OFFICE USE ONLY:

Patient offered genetic testing:

☐ Accepted ________ ☐ Declined ________ ☐ Not Applicable

☐ Follow-up appointment scheduled:

Date: ______________

____

Health Care Provider's Signature Date

Health Assessment for Women

Name: ______________________ Date: ______________________
Height: ____________ Weight: ____________
Email: ____

(Please Check Appropriate Box)

Symptom	Never	Mild	Moderate	Severe	ICD-10
Depressed Mood					F33.0/F41.8
Fatigue					R53.83
Memory Loss					R41.3
Mental Confusion					R41.3
Decreased Libido					R68.82
Sleep Problems					G47.00
Mood Changes/Irritability					F41.8
Tension					
Migraine/Severe Headaches					R51
Difficulty Achieving Orgasm					R62.82
Bloating					R14.0
Weight Gain					R63.5
Breast Tenderness					N64.4
Vaginal Dryness					
Hot Flashes					E34.9/N95.1
Night Sweats					R61.9
Hair Falling Out					L65.9
Cold all the Time					
Joint Pain					M25.50

Family History (Check all that apply)

___ Breast Cancer

___ Diabetes

___ Osteoporosis

___ Alzheimer's Dementia

___ Heart Disease

Personal History (Check all that apply)

___ Still Menstruating

___ Hysterectomy

___ Polyps/Fibroids

___ Breast Cancer

___ Hormone Therapy ?

What Type?

___ PCOS

___ Excess Facial Hair

___ Pregnant

___ Epilepsy

___ Thyroid Meds?

Which One?