Patient Registration Form

Return by email to admin@obgynsoc.com or by fax to (706)

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

Name _____ Gender _____ Age _____ Date of Appointment: _____

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 (Your Personal Medical Hisory)

☐ Alcoholism ☐ Allergies ☐ Anemia ☐ Anxiety Disorder ☐ Arthritis ☐ Asthma ☐ AIDS / HIV
☐ Back Problems ☐ Bleeding Disorder ☐ Blood Disease ☐ Blood Transfusion ☐ Cancer ☐ Diabetes ☐ Depression
☐ Blood clot and/or a pulmonary embolism ☐ Eating Disorder ☐ Epilepsy ☐ Glaucoma ☐ Atrial fibrillation or other arrhythmia ☐ Heart Disease ☐ Heart Problems ☐ Heart attack
☐ Hepatitis - A, B, or C ☐ High Blood Pressure ☐ High Cholesterol ☐ Joint Disorder ☐ Kidney Disorder ☐ Liver Disorder ☐ Lung Disease ☐ Liver disease (hepatitis, fatty liver, cirrhosis)
☐ Measles ☐ Migraines ☐ Osteoporosis ☐ Pneumonia ☐ Polio ☐ Rheumatic Fever ☐ Stroke
☐ Skin Disorder ☐ Stomach Ulcer ☐ Substance Abuse ☐ Thyroid Disorder/disease ☐ Tuberculosis ☐ Venereal Disease ☐ Psychiatric disorder ☐ Lupus or other autoimmune disease ☐ Other: _____

Hospitalizations & Surgeries

Reason	Date

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 _____

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:

Name _____ Gender _____ Age _____ Date of Appointment: _____

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?

☐ Menopause ☐ Tubal Ligation ☐ Vasectomy ☐ Infertility
☐ Hysterectomy ☐ Birth control pills ☐ IUD ☐ Other _____

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		

OBGYN
Specialists of Columbus

1604 12th Street Columbus, GA 31906 Phone:706-324-0471 Fax: 706-324-0473

Name: _____ **Date of birth:** _____

Weight: _____ **Height:** _____

FEMALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box(X)for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)					
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina, or motivation)					
Difficulties with memory					
Problems with thinking, concentrating, or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places or things when speaking					
Sexual problems (change in sexual desire, sexual activity, orgasm and/or satisfaction)					
Sleep problems					
Irritability (mood swings, feeling aggressive, angers easily)					
Increase in frequency or intensity of headaches or migraines					
Bloating					
Weight gain or difficulty losing weight despite diet and exercise					
Breast tenderness					
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)					
Hot flashes					
Sweating (night sweats or increased episodes)					
Dry or wrinkled skin					
Hair loss, thinning or change in texture of hair					
Feel cold all the time or have cold hands or feet					
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)					
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)					
Total score					

Patient Name:

MyRisk™

Hereditary Cancer Test

Check the boxes below based on your personal and family history of cancer. Leave blank what you do not know.

Do you have a personal history of:

Breast, ovarian, or pancreatic cancer at any age?	☐ YES	☐ NO
Colorectal cancer or endometrial/uterine cancer at age 64 or younger?	☐ YES	☐ NO

Has any relative (parent, sibling, half-sibling, child, grandparent, grandchild, aunt/uncle, niece/nephew) been diagnosed with:

Breast cancer at age 50 or younger?	☐ YES	☐ NO
Three breast cancers in relatives on the same side of the family at any age?	☐ YES	☐ NO
Ovarian Cancer at any age?	☐ YES	☐ NO
Two breast cancers (bilateral) in one relative at any age?	☐ YES	☐ NO
Male breast cancer at any age?	☐ YES	☐ NO

Has a parent, sibling, or child been diagnosed with:

Pancreatic cancer at any age?	☐ YES	☐ NO
Colorectal cancer at age 49 or younger?	☐ YES	☐ NO
Endometrial cancer at age 49 or younger?	☐ YES	☐ NO

If you answered "YES" to ANY of the questions above, scan the QR code above to complete a brief assessment to see if you meet medical criteria for genetic testing.

Show your results to your healthcare provider today and ask about how genetic testing can benefit you and your family.

OFFICE USE ONLY Patient offered genetic testing: Yes/No Accepted/Declined Provider Initials: _____

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 pr ovider 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. *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 $100/ Procedures $150. All hospital surgery procedures will be charged at a rate of $250. If not given a 7 day 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:*_____

OBGYN
Specialists of Columbus

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: _____

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Phone: 706-324-0471 Fax: 706-324-0473
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OBGYN
Specialists of Columbus

Our goal is to provide quality individualized medical care in a timely manner to our patients. No shows and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

To be respectful of the medical needs of other patients, please be courteous and call OBGYN Specialists of Columbus promptly if you are unable to show up for your appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another patient the possibility to access timely medical care.

To cancel your appointment, please call 706-324-0471 or send a message through your patient portal.

If you do not cancel 24 hours in advance or no show your appointment, we will charge a $100 late cancellation/no show fee that is required to be paid before the next appointment can be scheduled.

When do I have to pay for preventive care?

If your provider finds a health problem or you bring up a problem that needs to be addressed during a wellness exam, you may have to pay. Why? Once a problem is found, your exam is no longer considered preventive it becomes diagnostic, or non-routine.

When diagnostic care is needed, your out-of-pocket costs depend on your coverage and test, or service needed. The government requires us to report all diagnoses to the insurance company. Your INSURANCE COMPANY determines what you pay at visits, not our office.

Portal Message and Phone Policy

If treatment is rendered through telephone and/or portal message evaluation and management, you will be billed for services rendered. These calls could be in reference to medical advice and/or treatment given over the phone. The fee for tele-visit is reimbursable by insurance and you will be responsible for any copay, coinsurance, or deductible.

Annual Wellness Exams

Dr. Rees no longer performs annual wellness examinations, these will be scheduled with the Nurse Practitioner. If you are having a problem and would like to see Dr. Rees for evaluation, please notify the staff so that an appointment for a problem visit can be scheduled with Dr. Rees.

Print Name: _____

Signature: _____ Date: _____