New Patient Information Packet

Thank you for choosing Advanced Gynecology Specialists. Our entire staff is dedicated to helping you maintain good health by providing you with quality care during the early stages of your pregnancy, annual and preventative healthcare checkups, or for any gynecological problems you may be experiencing.

We look forward to your visit and the opportunity to discuss any health concerns you may have. Our office is located at 7013 Evans Town Center Blvd. in Suite 101. Our phone number is 706-922-4545.

To make your first visit as stress-free as possible we have prepared the various forms we need in this New Patient Information Packet including:

- Patient Registration Form
- Basic Health Questionnaire
- Detailed Health History
- Medical Services Waiver
- Authorization for Release of Protected Health Information
- Request for Medical Records Letter

We realize completing these forms can be a little inconvenient, so we have attempted to eliminate as much duplication as possible. To minimize your time in our office, please complete these forms prior to your appointment.

- Drop off these forms at our office at least one week before your first appointment **or**
- Mail these forms to the address below at least ten days before your appointment **or**
- Fax these forms to 1-866-777-2246 at least five days before your appointment.

Advanced Gynecology Associates of Augusta
7013 Evans Town Center Blvd. Suite 101
Evans, GA 30809

ADVANCED gynecology Specialists of Augusta

Patient Registration Form

Patient #:

PATIENT INFORMATION			
Today's Date:	SS#:	Date of Birth:	
Last Name:	First Name:		Middle Initial:
Mailing Address:			
City, State, Zip Code:			
Email Address:			
Home Phone:	Cell Phone:		
Employer:		Occupation:	
Employer Mailing Address:		Work Phone:	
City, State, Zip Code:		City, State, Zip Code:	
Spouse's Name:			
Emergency Contact:		Phone Number:	

INSURANCE INFORMATION	
Primary Insurance:	Policy/Subscriber:
Address:	Insured Policy ID:
City/State/Zip	Group#:
Plan Phone:	Effective Date of Plan:
Patient Relationship to Subscriber:	Date of Birth:
Secondary Insurance:	Policy/Subscriber:
Address:	Insured Policy ID:
City/State/Zip	Group#:
Plan Phone:	Effective Date of Plan:
Patient Relationship to Subscriber:	Date of Birth:

FINANCIALLY RESPONSIBLE PARTY Complete this section only if the information is different from the Patient Information Section	
Account #:	Guarantor's Relationship to Patient:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated	Gender: ☐ Male ☐ Female
Last Name:	Date of Birth:
First Name:	SS#:
Address:	Phone:
City/State/Zip	
Employer:	Phone:
Address:	City/State/Zip:

PARENT/LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION (PATIENTS 18 AND YOUNGER) Complete this section if different from the information provided in the Financial Responsibility section	
Parent/Guardian Name:	Emergency Contact:
Address:	Address:
City/State/Zip:	City/State/Zip
Parent Home Phone:	Contact Home Phone:
Parent Work Phone:	Contact Work Phone:

PRIMARY CARE PHYSICIAN'S INFORMATION	
Name:	Phone:
Group Name:	
City/State/Zip:	

PREFERRED PHARMACY CONTACT INFORMATION This is very important, especially if you use a mail order or online pharmacy	
Name of Pharmacy:	Location:
Phone Number:	Fax Number:
City/State/Zip:	

HOW DID YOU HEAR ABOUT OUR PRACTICE?

MEDICAL AUTHORIZATION AND RELEASE OF INFORMATION
OUR FINANCIAL POLICY: Unless other arrangements have been made in advance, payment is due at the time of service. Co-payments are always due at the time of your visit. For your convenience, we accept personal checks, cash, Visa and MasterCard. If you do not have active insurance coverage or do not have documentation of your coverage, we will ask that you pay for services at the time of your visit. We require our staff to check your insurance card at each visit, so please have it ready at the time of check-in. We participate with most major carriers and will bill those plans with which we have an agreement. All co-payments or deductibles are due at the time of service. In the event your health plan determines a service to be not covered, you will be responsible for the charges. If you have insurance coverage through a plan with which we do not have an agreement, we will prepare and send the claim for you as a courtesy; however, payment is still your responsibility at the time of service. We will submit claims to your health care plan for services provided in the hospital. However, your portion of the deductible and coinsurance must be paid in advance of your planned surgery or estimated delivery. Additional professional services such as lab work, radiology and anesthesia services will be billed separately and will not be part of the charges from our office. We use the services of an outside collection agency for past due accounts. In the event that attorney and/or court fees are required to collect your account balance you will be responsible for those charges in addition to your charges from our practice. Patients with accounts in bad debt will not be allowed to schedule further appointments until the balance is paid in full. MINORS: all services rendered to minors will be the financial responsibility of the adult accompanying the minor. I have read and understand the financial policy of Advanced Gynecology Associates Augusta and I agree to be bound by its terms. By entering my name below I agree to the above
Signature _____ Date _____ Do you authorize us to release medical records to your other health care providers? ☐ Yes ☐ No The telephone number we can call to leave a detailed message: _____

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Basic Health Questionnaire

Today's Date: _____

Patient's Name _____ Date of Birth: _____

HEALTH & FITNESS

1. Are you happy with your current weight? ☐ Yes ☐ No
2. Are you interested in finding out about a medically supervised weight loss program? ☐ Yes ☐ No

MENSTRUAL CYCLE

1. How would you describe the volume of your menstrual bleeding? ☐ Light ☐ Normal ☐ Heavy
2. Do your heavy periods affect your social life, fitness or sexual intimacy? ☐ Yes ☐ No
3. Do you miss work because of your periods? ☐ Yes ☐ No

BIRTH CONTROL

1. Are you happy with your current form of birth control? ☐ Yes ☐ No
2. Are you interested in permanent sterilization? ☐ Yes ☐ No
   (**NOTE: if you are not done with childbearing, this option is not for you)**

GYN HEALTH

1. Have you suffered with ovarian cysts or fibroids? ☐ Yes ☐ No
2. Do you have irregular bleeding or pelvic pain? ☐ Yes ☐ No
3. Do you suffer from any of the following?

☐ Problems Emptying Your Bladder Completely
☐ Problems Starting to Urinate
☐ Painful Urination
☐ Recurrent Urinary Tract Infections
☐ Incontinence
☐ Frequent Urination
☐ Sudden, Strong Urges to Urinate

PRESENT COMPLAINT

_____

_____

_____

_____

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Detailed Health History

Today's Date: _____

Patient's Name _____ Date of Birth: _____

Reason for Visit: ☐ Routine Annual ☐ Problem (please describe): _____

MEDICAL HISTORY

Please review this sheet and mark any condition you have or have had in the past. If you are uncomfortable answering any of these questions, leave them blank. You can discuss them with Dr. Thaxton or his nurse

☐ I have reviewed the information on this page and I have no past medical history to report.

Breast	Yes	No
Breast cancer		
Fibrocystic breast disease		
Breast lumps		
Other:		
Cancer of	**Yes**	**No**
Colon		
Ovary		
Skin		
Uterus		
Other:		
Cardiovascular	**Yes**	**No**
Hypertension		
Heart attack		
High cholesterol		
Mitral valve prolapse		
Other:		
Dexa/Mamm/Pap (provide date)	**Yes**	**No**
Dexascan		
Mammogram		
Other:		
Digestive	**Yes**	**No**
Stomach ulcer		
Colitis		
Reflux disease		
Hepatitis		
Other:		

Gynecologic	Yes	No
Fibroid tumors		
Endometriosis		
Ovarian cysts		
Sexually transmitted diseases		
Cancer/pre-cancer cervix		
Other:		
Injury/Poisonings	**Yes**	**No**
Motor vehicle accident		
Pelvic fractures		
Hip fractures		
Other:		
Hematologic	**Yes**	**No**
Anemia		
Sickle cell		
Clots in legs or pelvis		
Von Willebrand Disease		
Factor V Leiden		
Pulmonary embolism		
Other:		
Musculoskeletal	**Yes**	**No**
Arthritis		
Rheumatoid arthritis		
Systemic lupus		
Osteoporosis		
Other:		

Neurologic	Yes	No
Seizures		
Migraines		
Strokes		
Other:		
Psychiatric	**Yes**	**No**
Depression		
Anxiety disorder		
Schizophrenia		
Other:		
Respiratory	**Yes**	**No**
Emphysema COPD		
Asthma		
Other:		
Urologic	**Yes**	**No**
Kidney stones		
Incontinence		
Other:		
Please list any conditions not shown		

FAMILY HISTORY

Please check yes or no on all that apply and indicate which relative was affected

Gynecologic	Yes	No	Relationship
Endometriosis			
Fibroids			
Cancer-Uterus			
Cancer-Ovary			
Cardiovascular	**Yes**	**No**	**Relationship**
Hypertension			
Heart attack			
Neurologic	**Yes**	**No**	**Relationship**
Stroke			

Respiratory	Yes	No	Relationship
Cancer-Lung	☐	☐	
Psychiatric	**Yes**	**No**	**Relationship**
Depression	☐	☐	
Hematologic	**Yes**	**No**	**Relationship**
Sickle Cell	☐	☐	
Leukemia	☐	☐	
Clots in legs	☐	☐	
Bleeding disorder	☐	☐	

Gastroenterology	Yes	No	Relationship
Cancer-Colon			
Breast	**Yes**	**No**	**Relationship**
Cancer-Breast			
Other:			

SURGICAL HISTORY
Please list all surgeries you have had

Surgery	Date	Surgery	Date

ALLERGIES

Do you have any allergies to medications, x-ray dyes, chemicals, etc.? ☐ Yes ☐ No If yes please provide details below.
Are you allergic to latex? ☐ Yes ☐ No
Have you or a family member ever had a reaction to anesthesia? ☐ Yes ☐ No If yes, please describe_____

Allergy	Reaction	Allergy	Reaction

MEDICATIONS YOU ARE TAKING
Please list medications you are currently taking

Drug Name	Dosage	Physician	Drug Name	Dosage	Physician

REPRODUCTION/MENSTRUAL HISTORY

Age when you had first period?	Cycle interval?
Periods last how many days?	Date of your last menstrual cycle?
Menopausal ☐ Yes ☐ No	Birth control method?

OBSTETRIC HISTORY

Total pregnancies?	Premature deliveries (less than 37 weeks): ☐ Yes ☐ No
Miscarriages ☐ Yes ☐ No Indicate how many	How many full term births (more than 37 weeks)?
Pregnancy Terminated? ☐ Yes ☐ No	Number of living children?

PREGNANCY HISTORY
Please provide information for each pregnancy, including abortions and miscarriages

Number	Date of Birth	Weeks gestational age	Sex	Weight	Vaginal or C Section	Complications
1						
2						
3						
4						
5						

SOCIAL HISTORY

Are you sexually active? ☐ Yes ☐ No	Do you have pain with intercourse? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No Number of times weekly?	Do you perform monthly self breast examinations? ☐ Yes ☐ No
Level of exercise? ☐ Fair ☐ Moderate ☐ Good	Do you drink alcohol? ☐ Never ☐ Minimal ☐ Moderate ☐ Heavy
Have you been a victim of domestic violence? ☐ Yes ☐ No	Do you smoke? ☐ Yes ☐ No ☐ Never ☐ Past How many per day?

Patient or Guardian (if under 18) Signature

Patient or Guardian Printed Name

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Medical Services Waiver

I understand I am presenting myself in the office today for medical services to be performed. While many insurance companies cover the services that may be performed such as an annual exam (including pap smear, breast exam, other age appropriate screenings), biopsies, colposcopies and injections, I have been informed that some insurance companies do not. If my insurance company does not pay Advanced Gynecology Services of Augusta for the services performed today I understand that any charges incurred during my exam will be my financial responsibility.

I understand that I will also be responsible for any copay or coinsurance payment due to Advanced Gynecology Services of Augusta at the time of service, per the requirements of my health insurance plan contract.

I also understand that I will be responsible for payment of charges in full if I do not have any health insurance coverage.

Lastly, I understand that if I require a referral or preauthorization for Advanced Gynecology Services of Augusta services or any additional services recommended by Advanced Gynecology Services of Augusta (including but not limited to radiology and lab work), I am responsible for either obtaining the correct referral OR notifying the office within 48 hours of the date of service to obtain an authorization. If I fail to do so, I will be responsible for the balances billed by Advanced Gynecology Services of Augusta or outside parties for these services.

_____ _____

Patient Signature Patient Printed Name

If patient is under 18:

_____ _____

Parent / Guardian Signature Parent/Guardian Printed Name

_____

Date of Service

Authorization for Release of Protected Health Information

CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

Patient's Name or Authorized Agent (Please Print): _____

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I hereby give my consent to Advanced Gynecology Associates of Augusta to use and disclose, for the purpose of carrying out Treatment, Payment, or Health Care Operations (TPO), all information contained in my patient record.

With this consent, Advanced Gynecology Specialists of Augusta may call my home or other alternative location and leave a message on voicemail or in person in reference to items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Advanced Gynecology Specialists of Augusta may mail to my home or other alternative location my items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to Advanced Gynecology Specialists of Augusta's use and disclosure of my Protected Health Information (PHI) to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Advanced Gynecology Specialists of Augusta may decline to provide treatment to me.

_____ _____
Signature of Patient Date

Authorization of Release of Protected Health Information to Family Members
I authorize Advanced Gynecology Specialists of Augusta to release protected health information to my family member(s) listed below:

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Signature of Patient Date

REQUEST FOR MEDICAL RECORDS

Authorization to Release Medical Records to Advanced Gynecology Specialists of Augusta

To Dr : _____ Date _____

_____

_____

_____

(Please print your name as it appears on medical records)

I, _____ hereby request that you release a complete copy of my medical records to:

Dr. Paul M. Thaxton
Advanced Gynecology Specialists of Augusta
7013 Evans Town Center Blvd. Suite 101
Evans, GA 30809
706-922-4545

FAX: 866-777-2246

Patient Signature _____ Date of Birth _____

Patient Address _____

City, State, Zip _____

This document is intended only for the use of the individual or entity it is addressed to and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If any document transmitted is viewed by anyone other than the intended recipient or authorized agent, you are hereby notified that any dissemination, distribution or copying of this communication or any document associated with it is strictly prohibited. If you have received this communication in error, please notify us immediately at the telephone number indicated herein and destroy all documents received.