MATERNAL GYNERATIONS

600 Professional Dr., Suite 200, Lawrenceville, GA 30046
2098 Teron Trace, Suite 150, Dacula, GA 30019
Call 770.513.4000 | Fax 770.237.2523
MaternalGynerations.net

PATIENT ACCOUNT # _____ Referred by: _____

Preferred Pharmacy, Address, Phone Number & City_____
By providing a pharmacy, I give permission to send and receive prescription information between Maternal Gynerations, PC and my pharmacy

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 □ Decline
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

Emergency Contact: _____Relationship: _____ Phone Number: _____

Is your insurance through (please circle 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: _____

DO YOU GIVE MATERNAL GYNERATIONS P.C. PERMISSION TO LEAVE VOICEMAILS REGARDING TEST RESULTS? □ Yes □ No
PATIENT'S INITIALS _____

I HAVE RECEIVED/READ A COPY OF MATERNAL GYNERATIONS. P.C. NOTICE OF PRIVACY PRACTICES. PATIENT'S INITIALS _____

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LAB BILLING POLICY

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

Unless you request differently, all lab work will be sent to Quest Diagnostics. If your insurance company requires it to be sent elsewhere, please let us know before any lab work is collected. Our office bills for the physician's office visit portion, but you will receive a separate bill directly from the lab for their processing of any specimens. Specimens obtained can include tissue, swab, or urine specimens, cultures, biopsies, pap smears, blood work, etc.

As a courtesy to the patient, any insurance information that you have provided prior to collection of the specimen will be given to the lab so that they can submit it for processing. However, this bill will remain the patient's responsibility. If no insurance information is given, then 100% of the lab charge will be billed directly to the patient by the lab.

If you have any questions, please ask our office personnel for clarification.

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

_____ _____

Patient Signature Date

_____ _____

Print Name Date of Birth

_____

Acct. #

MATERNAL GYNERATIONS - PROBLEM VISIT

Name	Birthdate
Reason for visit:	First day of your last menstral period:

Are you taking any new medications?

Do you currently have a sexual partner? □ No □ Yes How long?

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/ Easy bruising Lymph node enlargement
LYMPHATIC: