DOUGLAS WOMEN'S CENTER PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY!

Patient's Full Name: ____
FIRST MIDDLE MAIDEN LAST

Nickname or Name Patient Prefers To Be Called: ____________________________________

Street Address:____**Lot # or Apt #**____________

City ________________________________**State** __________ **Zip Code**___________

VERY IMPORTANT! PLEASE PROVIDE ALL CURRENT CONTACT NUMBERS WHERE YOU CAN BE REACHED:

Home Phone#: _______________________**Work Phone#**: ___________________________

Cell Phone#: _______________________ **Any Other #'s**: ___________________________

Social Security#: ___________________**Date of Birth**: __________________**Marital Status** ____________

Employer: ____________________**Employer Address:** _______________________________

Primary Physician or Personal Physician (other than Douglas Women's Center): ____________________

Referred By: ___________________ **Allergies:** ________________________________

INFORMATION FOR SPOUSE:

Spouse Name: ______________________________ **Spouse Date of Birth**:___________________

Employer____________________ **Employer Address**: _____________________________

Spouse Work Phone#:________________ **Spouse Cell #:** ________________ **Spouse Social Security #:**____________________

PLEASE PROVIDE TWO EMERGENCY CONTACTS:

1) Name:_____________________ Relationship To Pt. ________ Home# _____________ Work# ____________ Cell#____________

2) Name:_____________________ Relationship To Pt. ________ Home# _____________ Work#_____________ Cell#___________

INSURANCE INFORMATION:

Primary Insurance Co ____

Name of Primary Card Holder: ________________________DOB: ______________Relationship to Patient: _____________

Claim Mailing Address: ____

ID#__________________________________Group#: ___________________________

Secondary Insurance Co: ____

Name of Primary Card Holder: ________________________DOB: ______________Relationship to Patient: _____________

Claim Mailing Address: ____

ID#__________________________________Group#: ___________________________

PLEASE READ THE FOLLOWING STATEMENTS AND WRITE YOUR INITIALS IN THE SPACE PROVIDED:

(INITIAL) ________I authorize Douglas Women's Center, P.C., to release to my insurance company information required in the course of my treatment.

(INITIAL) ________I hereby assign payment directly to Douglas Women's Center, P.C. for medical benefits payable for these services. I understand that I am responsible for any charges not paid under this assignment and/or for any non-covered service.

_______________________________________ _______________________
Signature of Patient Date

_______________________________________ _______________________
Signature of Responsible Person if Patient is a Minor Date

Revised 02/17/12 ***(Office Use Only) Acct. #*** _______________***Emp. Init.*** ______

Douglas Women's Center
Confidential Health Questionnaire

Name: ________________________________ Date of Birth:____/____/____ Today's Date: ____/____/____

REASON FOR VISIT (Please check appropriate box)**:** ☐ **ANNUAL EXAM** ☐ **PROBLEM EXAM**

Please explain any problems or concerns:

CURRENT MEDICATIONS, VITAMINS AND HERBAL SUPPLEMENTS:

DRUG NAME:	DOSAGE:	DRUG NAME:	DOSAGE:	DRUG NAME:	DOSAGE:

DRUG ALLERGIES:

GYN HISTORY:

Last menstrual period or hysterectomy (Date) ____/____/____	Date of last pap smear ____/____/____
Periods: Regular ☐ Irregular ☐	History of Abnormal Pap Smears? Yes ☐ No ☐
How far apart are your periods?	Do you use any kind of birth control? Yes ☐ No ☐
How long does your period last?	Type: How Long?
Painful periods? Yes ☐ No ☐	Are you satisfied with this method? Yes ☐ No ☐
Are periods Light ☐ Moderate ☐ Heavy ☐	What other birth control methods have you used? List below:
Sexually active Yes ☐ No ☐	
Painful intercourse Yes ☐ No ☐	# pregnancies _____ # births: _____ # miscarriages: _____
Any vaginal discharge, itching or odor? Yes ☐ No ☐	Any urinary burning, frequency or pressure? Yes ☐ No ☐

REVIEW OF SYSTEMS:

Please mark (x) if any of the following apply to you now, in the past or often

	Current	Past		Current	Past
CONSTITUTIONAL			**URINARY**		
Weight Loss	☐	☐	Blood in Urine	☐	☐
Weight Gain	☐	☐	Pain with Urination	☐	☐
Fever	☐	☐	Urgency	☐	☐
Fatigue	☐	☐	Frequency of Urination	☐	☐
CARDIOVASCULAR			Incomplete Emptying	☐	☐
Chest Pain	☐	☐	Stress Incontinence	☐	☐
Swelling of Legs	☐	☐	**MUSCULOSKELETAL**		
Palpitations of Heart	☐	☐	Muscle Weakness	☐	☐
RESPIRATORY			**ENDOCRINE**		
Wheezing	☐	☐	Dry Skin	☐	☐
Spitting Up Blood	☐	☐	Abnormal Thirst	☐	☐
Shortness of Breath	☐	☐	Hot Flashes	☐	☐
GASTROINTESTINAL			**HEMATOLOGIC/LYMPHATIC**		
Diarrhea, frequent	☐	☐	Bruises, frequent	☐	☐
Bloody Stool	☐	☐	Cuts do not stop Bleeding	☐	☐
Nausea/Vomiting	☐	☐	Enlarged Lymph Nodes	☐	☐
Constipation	☐	☐	**PSYCHIATRIC**		
BREAST			Depression	☐	☐
Pain in Breast	☐	☐	Crying, Frequent	☐	☐
Discharge	☐	☐	Anxiety	☐	☐
Masses	☐	☐			

If you have checked any of the above, are you currently receiving treatment or evaluation for the conditions(s)?

Douglas Women's Center
Confidential Health Questionnaire

Name: ___________________________________ Date of Birth:____/____/____ Today's Date: ____/____/____

PERSONAL PAST HISTORY (Major Illnesses)

Illness	Yes	No	Illness	Yes	No
Asthma			Cancer (Specify Type)		
Chronic Lung Disease			Ulcers		
Kidney Infections/Stones			Depression/Anxiety		
History of Endometriosis			Anemia/Blood Transfusions		
Sexually Transmitted Disease			Seizures/Convulsions/Epilepsy		
Heart Trouble/Murmur			Bowel Trouble		
Diabetes			Glaucoma		
High Blood Pressure			Fracture		
Stroke			Hepatitis/Yellow Jaundice		
History of Fibroids			Thyroid Disease		
Any other illnesses not listed above? *If yes, please explain:*					
Any recent hospitalizations?			*Explain:*		
Any recent surgeries?			*Explain:*		
Any recent health issues?			*Explain:*		
Have you had a colonoscopy?			If Yes, When? ____/____/____		

ANY NEW FAMILY HISTORY?

Illness	Yes	No	Illness	Yes	No
Diabetes			Breast Cancer		
Stroke			Colon Cancer		
Heart Disease			Ovarian Cancer		
High Blood Pressure					
Other? (Please specify)					

SOCIAL HISTORY CHANGES:

Marital Changes? Yes □ No □

Married □ Single □ Widowed □ Divorced □

	Yes	No	
Alcohol			Drinks Per Day? ________ Drinks Per Week?________
Drug Use			
Regular Exercise			
Smoking			Packs per day__________________ # of Years _________

PLEASE CHECK ALL THAT APPLY:

□ I am due for a Mammogram
□ I am due for DEXA aka: Bone Density Screening (Performed Every Two Years)
□ I desire STD Testing
□ I desire Birth Control
□ I want to discuss Permanent Birth Control
□ I want blood work drawn
□ I want a pregnancy test today

PRIMARY CARE PHYSICIAN INFORMATION:

What is the name of your Primary Care Physician?: ____

Do you see your Primary Care Physician Yearly? Yes □ No □

When was the last time you visited your Primary Care Physician for an annual physical? _____________________

DOUGLAS WOMEN'S CENTER
Method of Contact &
Permission To Leave Health Information With Persons Other Than Patient
Authorization Form

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please note, the referring physician or referral source may be sent a copy of records to ensure continuity of care.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

Home Telephone

- O.K. to leave message with detailed information ____
- Leave message with a call back number only ____
- Do not leave message ____

Work Telephone

- O.K. to leave message with detailed information ____
- Leave message with a call back number only ____
- Do not leave message ____

Written Communication

- O.K. to mail to my home address ____
- O.K. to mail to my work/office address ____
- O.K. to fax to this number __________________ ____
-

Cell Phone

- O.K. to leave message with detailed information ____
- Leave message with a call back number only ____
- Do not leave message ____

I AUTHORIZE DOUGLAS WOMEN'S CENTER TO LEAVE INFORMATION WITH THE FOLLOWING PEOPLE:

Name:	Relationship:

Patient Signature	**Date:**	
Print Name:	**Social Security #:**	**Birth Date:**

The Doctors and Staff of Douglas Women's Center Want You to Know How We Will Protect Your Private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA'). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

- Give patients more control over their health information;
- Set boundaries for the use and release of health records;
- Establish safeguards that physicians, health plans and others healthcare providers must have in place to protect the privacy of health information;
- Hold violators accountable, with civil & criminal penalties; and
- Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that our practice provide all of our patients that we see after April 14, 2003 with the attached Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of the attached Notice to review. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our office manager/Privacy Officer.

Thank you for your cooperation.

I acknowledge that I have received a copy of Douglas Women's Center's Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient Name: ____
(Please Print)
Signature of Patient or Personal Representative:

______________________________________ **Date:** ________________

If Personal Representative, give relationship to patient:
____

YOU WILL BE ASKED TO SIGN A COPY OF THIS ON YOUR NEXT APPOINTMENT.
THIS COPY IS FOR YOUR RECORDS.

DIRECTIONS TO DOUGLAS WOMEN'S CENTER

880 Crestmark Drive, Suite 200
Lithia Springs GA 30122

From Atlanta:

I-20 West to Thornton Road exit #44 – turn right off ramp.
Go to second traffic light turn left onto Skyview Drive
Turn left at first street onto Crestmark Drive
Go around curve to last building on left, 880 Crestmark Dr., Suite 200 (upstairs)
(second light gray building with blue roof behind Shoney's Inn & McDonalds)

Toward Atlanta:

I-20 east to Thornton Rd exit #44 – turn left off ramp
Go to third traffic light turn left onto Skyview Drive
Turn left at first street onto Crestmark Drive
Go around curve to last building on left, 880 Crestmark Dr., Suite 200 (upstairs)
(second light gray building with blue roof behind Shoney's Inn & McDonalds)

If you have any problems locating our office, please call 770-941-8662