

WELCOME TO THE WOMEN'S GROUP OF GWINNETT, P.C.

Please complete the forms prior to your scheduled visit. We recommend you arrive at least twenty minutes prior to your scheduled time with these forms **completed**. Having all paperwork completed at the time of your arrival helps us provide quality care in a timely fashion. **PLEASE BE SURE TO BRING YOUR INSURANCE CARD AND PHOTO I.D. IF YOU WERE REFERRED BY ANOTHER PHYSICIAN, PLEASE BRING ANY RECORDS FROM THE REFERRING PHYSICIAN.**

In the practice of obstetrics and gynecology, emergencies arise that interrupt the normal flow of the office practice, which may cause us to run behind. We appreciate your patience and understanding.

Thank you.

Thomas A. Grillo, M.D.
William D. Haberstroh, D.O.
A. Neil Harrison, M.D.
Sabrina O. Faulkner, M.D.
Kristine E. Gould, M.D.
Yolonda M. Smith, M.D.

To: All OB Patients

From: The Women's Group of Gwinnett, P.C.

When you come for your first OB visit, you will need to bring all insurance cards. It is imperative that you give us the information regarding all insurance coverage. Failure to do so may result in your being responsible for the entire payment of all charges.

If you have coverage through your employer and are covered by your spouse's insurance, according to the law your insurance will always be primary. Also, if you have Medicaid, your insurance would be primary and Medicaid secondary.

If your insurance coverage changes during your pregnancy, please let us know immediately.

PATIENT REGISTRATION & HEALTH QUESTIONNAIRE – PLEASE PRINT

This form is to be completed annually

NAME _____ NICK NAME _____ DATE OF BIRTH _____

MARITAL STATUS: **S** Yes No **M** Yes No **W** Yes No **D** Yes No **SEP** Yes No

STREET ADDRESS _____ CITY, ST, ZIP _____

PHONE # - HOME _____ WORK _____ EMPLOYER _____

CELL PHONE # _____ SS # _____ REFERRED BY _____

SPOUSE'S NAME _____ DATE OF BIRTH _____ SS # _____

EMPLOYER _____ WORK # _____

IF UNDER 18 - PARENT / GUARDIAN _____

EMERGENCY CONTACT (OTHER THAN SPOUSE) _____ PHONE _____ RELATIONSHIP _____

Please list any allergies or drug sensitivities _____

INSURANCE & BILLING INFORMATION

1. INSURANCE COMPANY _____ EFFECTIVE DATE _____

NAME OF INSURED _____ RELATION TO PATIENT _____ GROUP # _____

INSURED'S DATE OF BIRTH _____ SS # _____

2. INSURANCE COMPANY _____ EFFECTIVE DATE _____

NAME OF INSURED _____ RELATION TO PATIENT _____ GROUP # _____

INSURED'S DATE OF BIRTH _____ SS # _____

MEDICARE # _____ MEDICARE I.D. # _____

NAME & ADDRESS OF PERSON RESPONSIBLE FOR BILL _____

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I allow fax transmittal of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered by The Women's Group of Gwinnett, P.C.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
I further authorize and request that insurance payments be made directly to The Women's Group of Gwinnett, P.C. should they elect to receive such payment.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Medical records consist of confidential information relating to your health. It is the policy of The Women's Group of Gwinnett, P.C. not to release medical records without the patient's prior written consent. I understand that any request for release of such medical records must be in writing at the time of such request.

Signature _____

Date _____

PARENT / GUARDIAN (please print) _____

Signature _____

Age 16 and under _____

OFFICE POLICY ON MANAGED CARE INSURERS

IN ORDER TO ACCOMMODATE THE NEEDS AND REQUESTS OF OUR PATIENTS WE HAVE ENROLLED IN NUMEROUS MANAGED CARE INSURANCE PROGRAMS.

WHILE WE ARE PLEASED TO BE ABLE TO PROVIDE THIS SERVICE TO YOU, IT IS EXTREMELY DIFFICULT FOR US TO KNOW ALL THE INDIVIDUAL REQUIREMENTS OF THE PLANS. EACH ONE HAS DIFFERENT STIPULATIONS REGARDING HOW OFTEN SERVICES MAY BE PERFORMED.

EVEN WITH THE SAME INSURANCE COMPANY THE PLANS DIFFER DEPENDING UPON WHAT TYPE OF CONTRACT YOUR EMPLOYER HAS NEGOTIATED.

PROVIDING QUALITY MEDICAL CARE FOR OUR PATIENTS IS OUR PRIMARY CONCERN; WE ARE MORE THAN WILLING TO PROVIDE THAT CARE WITHIN YOUR INSURANCE CONTRACT GUIDELINES IF YOU LET US KNOW AT EACH TIME OF SERVICE WHAT THOSE GUIDELINES ARE.

UNFORTUNATELY, IF YOU DO NOT INFORM US OF ANY SPECIAL REQUIREMENTS IN YOUR CONTRACT AND WE SUBSEQUENTLY ORDER SERVICES, SUCH AS LAB WORK OR HOSPITALIZATION, THAT ARE NOT COVERED AT THE SELECTED MEDICAL FACILITY, WE WILL HAVE NO CHOICE BUT TO BILL YOU DIRECTLY FOR THOSE CHARGES. PAYMENT FOR THOSE CHARGES IS THEN YOUR RESPONSIBILITY.

ALSO, ANY SERVICES NOT COVERED BY YOUR INSURANCE WILL BE YOUR RESPONSIBILITY.

IF SERVICES ARE PROVIDED AND YOUR COVERAGE IS NOT IN EFFECT ON THAT DAY, THE FEES SUBMITTED AND DENIED BY YOUR CARRIER WILL BECOME YOUR RESPONSIBILITY.

WITH YOUR COOPERATION AND HELP, YOU SHOULD BE ABLE TO RECEIVE ALL OF THE BENEFITS OFFERED TO YOU, AND WE WILL BE ABLE TO CONCENTRATE ON CARING FOR YOUR MEDICAL NEEDS.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

PATIENT AND/OR INSURED

DATE

**THE WOMEN'S GROUP OF GWINNETT, P.C.
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

I, _____, have been informed that a copy of **THE WOMEN'S GROUP OF GWINNETT, P.C.** Notice of Privacy Practices is posted on their web site and in the office.

Signature

Date

It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail or cell phone. However, we will confirm appointments by telephone. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

I authorize The Women's Group of Gwinnett to contact me at the following places:

Home telephone	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cell phone/voice mail	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Work telephone	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Answering machine	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cell phone number	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please list names of people with whom we may discuss your medical care:

Spouse Name _____ Yes No

Parent Name _____ Yes No

Other Name _____ Yes No

Please list names of people with whom we may discuss your financial information.

Signature of Patient/Guardian

Date

Health History Summary Date: mo / day / hr.		THE WOMEN'S GROUP OF GWINNETT, P.C. (770) 979-4700				PATIENT IDENTIFICATION													
						Patient's Name _____ Home Address _____ <div style="text-align: right;">STREET</div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> CITY STATE ZIP </div>													
Age _____		Date of Birth mo / day / yr _____		Race or Ethnicity _____		Religion _____		Marital status _____		Years married _____		Education _____							
Social Security Number _____				Occupation _____				Work Tel. No. _____		Home Tel. No. _____									
Alternate Contact _____				Relation to Patient _____				Work Tel. No. _____		Home Tel. No. _____									
Referring Physician _____				Attending Physician _____				OPTIONAL FOR INSURANCE, ETC.											
Medical History												Preexisting Risk Guide Indicates pregnancy/outcome at risk							
Check and detail positive findings including date and place of treatment. Precede by reference number.																			
<table border="0" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="width: 25%;"></td> <td style="width: 5%; text-align: center;">Patient</td> <td style="width: 5%; text-align: center;">Family</td> <td style="width: 40%;"></td> <td style="width: 20%;"></td> </tr> </table>														Patient	Family				
		Patient	Family																
1.	Congenital anomalies.....	<input type="checkbox"/>	<input type="checkbox"/>			31. <input type="checkbox"/> Age < 15 or > 35													
2.	Genetic diseases.....	<input type="checkbox"/>	<input type="checkbox"/>			32. <input type="checkbox"/> <8 th grade education													
3.	Multiple births.....	<input type="checkbox"/>	<input type="checkbox"/>			33. <input type="checkbox"/> Cardiac disease (class 1 or II)													
4.	Diabetes mellitus.....	<input type="checkbox"/>	<input type="checkbox"/>			34. <input type="checkbox"/> Tuberculosis, active													
5.	Malignancies.....	<input type="checkbox"/>	<input type="checkbox"/>			35. <input type="checkbox"/> Chronic pulmonary disease													
6.	Hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>			36. <input type="checkbox"/> Thrombophlebitis													
7.	Heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>			37. <input type="checkbox"/> Endocrinopathy													
8.	Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>			38. <input type="checkbox"/> Epilepsy (on medication)													
9.	Pulmonary disease.....	<input type="checkbox"/>	<input type="checkbox"/>			39. <input type="checkbox"/> Infertility (treated)													
10.	GI problems.....	<input type="checkbox"/>	<input type="checkbox"/>			40. <input type="checkbox"/> 2 abortions (spontaneous/induced)													
11.	Renal disease.....	<input type="checkbox"/>	<input type="checkbox"/>			41. <input type="checkbox"/> > 7 deliveries													
12.	Genitourinary tract problems.....	<input type="checkbox"/>	<input type="checkbox"/>			42. <input type="checkbox"/> Previous preterm or SGA infants													
13.	Abnormal uterine bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>			43. <input type="checkbox"/> Infants > 4,000 gms													
14.	Infertility.....	<input type="checkbox"/>	<input type="checkbox"/>			44. <input type="checkbox"/> Isoimmunization (ABO, etc.)													
15.	Venereal disease.....	<input type="checkbox"/>	<input type="checkbox"/>			45. <input type="checkbox"/> Hemorrhage during previous preg.													
16.	Phlebitis, varicosities.....	<input type="checkbox"/>	<input type="checkbox"/>			46. <input type="checkbox"/> Previous preeclampsia													
17.	Neurologic disorders.....	<input type="checkbox"/>	<input type="checkbox"/>			47. <input type="checkbox"/> Surgically scarred uterus													
18.	Metabol./endocrine disorders.....	<input type="checkbox"/>	<input type="checkbox"/>			48. <input type="checkbox"/> Preg. Without familial support													
19.	Anemia/hemoglobinopathy.....	<input type="checkbox"/>	<input type="checkbox"/>			49. <input type="checkbox"/> Second pregnancy in 12 months													
20.	Blood disorders.....	<input type="checkbox"/>	<input type="checkbox"/>			50. <input type="checkbox"/> Smoking (> 1 pack per day)													
21.	Drug abuse.....	<input type="checkbox"/>	<input type="checkbox"/>			51. <input type="checkbox"/> _____													
22.	Smoking/alcohol use.....	<input type="checkbox"/>	<input type="checkbox"/>			52. <input type="checkbox"/> _____													
23.	Infectious diseases.....	<input type="checkbox"/>	<input type="checkbox"/>			53. <input type="checkbox"/> _____													
24.	Operations/accidents.....	<input type="checkbox"/>	<input type="checkbox"/>			Indicates pregnancy/outcome at high risk													
25.	Allergies/meds sensitivity.....	<input type="checkbox"/>	<input type="checkbox"/>			54. <input type="checkbox"/> Age > 40													
26.	Blood transfusions.....	<input type="checkbox"/>	<input type="checkbox"/>			55. <input type="checkbox"/> Diabetes mellitus													
27.	Other hospitalizations.....	<input type="checkbox"/>	<input type="checkbox"/>			56. <input type="checkbox"/> Hypertension													
28.	_____	<input type="checkbox"/>	<input type="checkbox"/>			57. <input type="checkbox"/> Cardiac disease (class III or IV)													
29.	_____	<input type="checkbox"/>	<input type="checkbox"/>			58. <input type="checkbox"/> Chronic renal disease													
30.	No known disease/problems.....	<input type="checkbox"/>	<input type="checkbox"/>			59. <input type="checkbox"/> Congenital/chromosomal anomalies													
						60. <input type="checkbox"/> Hemoglobinopathies													
Menstrual History		Onset age		Cycle q. days		Length age		Amount age		L M P		mo / day / yr		quality					
Pregnancy History		Grav		Term		Pret		Abort		Live		E D C		mo / day / yr		quality			
No.	Month/year	Sex	Weight at Birth	Wks. gest.	Hrs. in labor	Type of delivery	Details of delivery: include anesthesia and maternal or newborn complications. Use Risk Guide numbers where applicable.					67. <input type="checkbox"/> Significant social problems							
1												68. <input type="checkbox"/> _____							
2												69. <input type="checkbox"/> _____							
												Historical Risk Status							
3												71. <input type="checkbox"/> No risk factors noted							
4												72. <input type="checkbox"/> At risk							
5												73. <input type="checkbox"/> At high risk							
6																			
7																			
8																			
												Signature							

PRENATAL GENETIC QUESTIONNAIRE

Please take time to answer the following questions as thoroughly as possible. The answers you provide will help your physician and genetic counselor identify any potential inherited or exposure-related risks to your unborn baby.

PATIENT NAME _____ PHYSICIAN _____

1. Will you be 35 years or older when your baby is born Yes No

2. Do you or the baby's father have a birth defect? Yes No
if yes, please indicate: _____

3. Do you have a child with a major birth defect or problem? Yes No
if yes, please explain: _____

4. Have any of the following occurred in your family or in the baby's father's family?

Bleeding disorder (e.g. hemophilia)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cystic fibrosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Muscular dystrophy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Spina bifida or anencephaly	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hydrocephaly	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Down syndrome or another syndrome	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other chromosomal abnormality	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of two or more miscarriages (indicate #)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart defect	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Severe anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Congenital kidney or liver disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Enzyme deficiency (e.g. PKU)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Huntington's Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Neurofibromatosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tumors of the eye (retinoblastoma)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If yes, please indicate relationship of the affected person to you or the baby's father.

5. Do any close relatives in either your family or the baby's father's family have a familial disorder not listed above? Yes No
if yes, please explain:

6. Do you or the baby's father have any close relatives with mental retardation? Yes No

If yes, please indicate relationship of the affected person to you or the baby's father, and the cause (if known):

7. Are you and the baby's father related to each other in any way (e.g. cousins)? Yes No
if yes, please explain:

A number of genetic diseases occur more commonly in certain ethnic groups. For this reason, it is important that we know your ethnic background.

8. Are you or the baby's father of Jewish or French-Canadian ancestry? Yes No
if yes, indicate who and the ancestry:

Have either of you been screened for Tay-Sachs disease? Yes No
if yes, indicate who and the results:

9. Are you or the baby's father of Black, Hispanic, Asian or Mediterranean ancestry? Yes No
if yes, indicate who and the ancestry:

if yes, indicate who and the ancestry:

Have either of you been screened for sickle cell trait? Yes No

if yes, indicate who and the results:

10. Are you or the baby's father of Philippine or Southeast Asian ancestry? Yes No

if yes, indicate who and the ancestry:

Have either of you been tested to determine if you are carriers of Alpha-thalassemia, a blood disorder? Yes No

if yes, indicate who and the results:

11. Do you have a chronic medical condition, such as diabetes, PKU or a thyroid problem? Yes No

if yes, list diagnosis:

12. Have you taken any medication during this pregnancy? Yes No
if yes, give name of medication and time taken during pregnancy:

13. During this pregnancy have you:

Had exposure to x-rays? Yes No

Had exposure to contagious illnesses? Yes No

Had any alcohol to drink? Yes No

Smoked any cigarettes? Yes No

Used any "recreational" drugs? Yes No

14. Do you have any history of Beta strep infection in pregnancy? Yes No

Good prenatal care depends on open communication. Please read the accompanying pamphlet and notify your physician if you recall or realize any new information about your family.

Provided as a courtesy to the medical genetics community by Integrated Genetics

THE WOMEN'S GROUP OF GWINNETT, P.C.

MEDICATION PRESCRIPTION POLICY

The physicians at The Women's Group of Gwinnett are happy to help you with your prescription needs. This includes supplying needed medication for our patients. We do have certain guidelines for refilling your medications prescribed by our physicians.

1. If you need a refill on your medication, we ask that you call your pharmacy at least 5-7 days prior to your refill and tell them which medication you need refilled. They in turn will contact us with all of the information we need to be able to refill the medicine.
2. **We do not refill medication after business hours or on weekends.** Our physicians do not have access to your medical records after business hours. Please make sure you contact your pharmacy before you take all your medication to allow time for the refill to be processed. All refills are authorized by the physician, so we must have ample time to contact the physician for authorization.
3. Any calls for medication received after 3:00 PM will not be addressed until the following business day. **If you call the answering service after hours for medication refills, the physician on call will not be paged.**
4. It is the policy of this office that a patient only receives narcotics from one treating physician. If you are receiving narcotic medications from another physician, we will not prescribe these for you.

I have read and understand the above policy on medication refills.

Patient name: please print _____

Patient signature: _____ Date: _____