# ANNISTON OB-GYN ASSOCIATES, P.C.

## Patient Information Sheet

***Welcome to Our Office!***

ACCOUNT #_____

PHYSICIAN _____ REFERRING PHYSICIAN _____

YOUR TELEPHONE # _____ YOUR ALTERNATIVE PHONE # _____

PATIENT NAME_____ SSN# _____/_____/_____
LAST FIRST MIDDLE

ADDRESS _____
STREET CITY STATE ZIP

PATIENT E-MAIL ADDRESS_____

Preferred Language _____ DOB___/___/____ AGE____ SEX____ RACE_____ MARITAL STATUS: ___S __ M __ W __

Ethnicity _____ Hispanic _____ Not Hispanic

EMPLOYER'S NAME _____ PHONE _____

SPOUSE'S NAME _____ DOB___/___/_____ SSN# _____/_____/_____

NOTIFY IN CASE OF AN EMERGENCY _____ PHONE _____
NAME RELATIONSHIP

***COMPLETE THIS SECTION IF YOU ARE AN UNMARRIED MINOR (UNDER 19)***

FATHER'S NAME _____ DOB___/___/_____ SSN# _____/_____/_____

FATHER'S EMPLOYER _____ PHONE_____

MOTHER'S NAME _____ DOB___/___/_____ SSN# _____/_____/_____

MOTHER'S EMPLOYER _____ PHONE_____

PARENTS' ADDRESS (IF DIFFERENT FROM YOUR OWN) _____

***INSURANCE INFORMATION***

DOES YOUR INSURANCE PAY FOR ROUTINE ANNUAL EXAMS? YES ____ NO ____ UNKNOWN ____

PRIMARY INSURANCE COMPANY _____ INSURED'S NAME _____

INSURED'S BIRTHDATE____/____/_____ RELATIONSHIP TO PATIENT _____

INSURED'S EMPLOYER _____

CONTRACT # _____ GROUP #_____ EFFECTIVE DATE ____/____/_____

SECONDARY INSURANCE COMPANY _____ INSURED'S NAME _____

INSURED'S BIRTHDATE____/____/_____ RELATIONSHIP TO PATIENT _____

INSURED'S EMPLOYER _____

CONTRACT # _____ GROUP #_____ EFFECTIVE DATE ____/____/_____

METHOD OF PAYMENT: ____ Cash ____ Check ____ Mastercard/Visa ***PAYMENT IS DUE AT TIME OF SERVICE

In consideration of services rendered, the undersigned agrees to pay Anniston OB-GYN Associates the charges thereof, insurance not withstanding. In the event collection action is initiated to collect such charges, the undersigned agrees to pay all costs and expenses of collection, including attorney's fees and court costs. I authorize Anniston OB-GYN Associates to release any medical information relating to my insurance claims. I authorize my insurance company to make direct payment to Anniston OB-GYN Associates for medical services rendered.

_____ _____
SIGNATURE DATE SIGNATURE DATE

_____ _____
SIGNATURE DATE SIGNATURE DATE

# OBSTETRICS AND GYNECOLOGY
# PATIENT HISTORY

Name _____ Date of Birth _____ Today's date _____

Primary Care Physician _____

Preferred Pharmacy _____ Pharmacy address _____ Phone _____

Reason for today's visit _____

_____

Date of last menstrual period _____

## OB HISTORY

| | NUMBER | | NUMBER | | NUMBER |
|---|---|---|---|---|---|
| Pregnancies | _____ | abortions | _____ | miscarriages | _____ |
| Premature births | _____ | live births | _____ | living children | _____ |

| BIRTH DATE | TYPE OF DELIVERY | WEEKS PREGNANCY | BIRTH WEIGHT | BABY'S SEX |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Pregnancy complications: diabetes ☐ high blood pressure ☐ other _____

History of depression before or after pregnancy? Yes ☐ No ☐ _____

## GYN HISTORY

How old were you when you had your first period? _____

Are your cycles regular/monthly? Yes ☐ No ☐

How many days does your period last? _____

If in menopause, at what age did it occur? _____

Years of hormone replacement therapy? _____

Are you currently sexually active? Yes ☐ No ☐

If not, have you ever been sexually active? Yes ☐ No ☐

Do you currently have a partner? Yes ☐ No ☐ Partner's gender _____

How long have you been in this relationship? _____

How many lifetime sexual partners have you had? _____

At what age was your first intercourse? _____

Have you ever been sexually abused, threatened or hurt by anyone? _____

Are you experiencing any sexual problems? _____

When was your last pap smear? _____

Have you had any abnormal pap smears? Yes ☐ No ☐ when? _____

Have you been told you have HPV? Yes ☐ No ☐ when? _____

Have you had any treatments for abnormal pap smears? Yes ☐ No ☐ repeat pap colposcopy biopsy

Have you received HPV vaccine? Yes ☐ No ☐ date _____

Have you ever had ovarian cysts? Yes ☐ No ☐

Have you been told you have fibroids of the uterus? Yes ☐ No ☐

Have you ever been treated for any sexually transmitted infections? Yes ☐ No ☐

☐ Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ Herpes ☐ Condyloma ☐ PID

Have you ever been tested for HIV? YES ☐ NO ☐ Date of last test? _____ Result? Neg ☐ Pos ☐

Current birth control

☐ None ☐ Timing ☐ Condoms ☐ Diaphragm ☐ Birth control pills ☐ Patch
☐ Implants ☐ Depo Provera ☐ IUD ☐ Tubal ligation ☐ Vasectomy ☐ Ring

Past birth control

☐ None ☐ Timing ☐ Condoms ☐ Diaphragm ☐ Birth control pills ☐ Patch
☐ Implants ☐ Depo Provera ☐ IUD ☐ Tubal ligation ☐ Vasectomy ☐ Ring

Have you ever had a yeast infection? Yes ☐ No ☐ Chronic? Yes ☐ No ☐

Have you ever been treated for a vaginal bacterial infection (bacterial vaginosis)? Yes ☐ No ☐ Chronic? Yes ☐ No ☐

Do you ever have problems with urinating such as infections, frequency, loss of urine, blood in your urine? Yes ☐ No ☐

If yes, please explain _____

When was your last mammogram? _____
Have you had any abnormal mammograms? Yes ☐ No ☐ _____
Have you had any breast biopsies? Yes ☐ No ☐ If yes, result _____
Do you do breast self examination? Yes ☐ No ☐

**HEALTH MAINTENANCE**

| Procedure | date | results |
|---|---|---|
| Last bone density | | |
| Last cholesterol | | |
| Last colonoscopy | | |

## MEDICAL HISTORY

| | | | |
|---|---|---|---|
| Arthritis | yes ☐ | no ☐ | _____ |
| Asthma | yes ☐ | no ☐ | _____ |
| Chronic lung disease | yes ☐ | no ☐ | _____ |
| Cancer | yes ☐ | no ☐ | _____ |
| Diabetes | yes ☐ | no ☐ | _____ |
| Eye disease | yes ☐ | no ☐ | _____ |
| Heart disease | yes ☐ | no ☐ | _____ |
| Hypertension | yes ☐ | no ☐ | _____ |
| Kidney disease | yes ☐ | no ☐ | _____ |
| Liver disease | yes ☐ | no ☐ | _____ |
| Psychiatric disorder | yes ☐ | no ☐ | _____ |
| Seizures/epilepsy | yes ☐ | no ☐ | _____ |
| Stomach/intestinal disease | yes ☐ | no ☐ | _____ |
| Stroke | yes ☐ | no ☐ | _____ |
| Thyroid disease | yes ☐ | no ☐ | _____ |
| Other | | | _____ |

## SURGICAL HISTORY

List any surgeries you have had and the approximate date
Example: tonsillectomy, appendectomy, gallbladder, tubal ligation, breast surgery/biopsy, laparoscopy

_____

_____

_____

_____

Have you had a blood transfusion? Yes ☐ No ☐ If yes, when_____

## FAMILY HISTORY — list any MEDICAL CONDITIONS of your relatives

Mother living/deceased _____

Father living/deceased _____

Siblings _____

| | | | ☐☐ Relationship to you |
|---|---|---|---|
| Diabetes | yes ☐ | no ☐ | _____ |
| Hypertension | yes ☐ | no ☐ | _____ |
| Thyroid disease | yes ☐ | no ☐ | _____ |
| Cancer | | | |
| Breast | yes ☐ | no ☐ | _____ |
| Ovarian | yes ☐ | no ☐ | _____ |
| Colon | yes ☐ | no ☐ | _____ |
| Other | | | _____ |
| Psychiatric illness | yes ☐ | no ☐ | _____ |
| Osteoporosis | yes ☐ | no ☐ | _____ |
| Other | yes ☐ | no ☐ | _____ |

## SOCIAL HISTORY

Occupation _____

Marital status single D married D separated ☐ divorced ☐ widowed ☐

Children _____

Pets _____

| | | | | | |
|---|---|---|---|---|---|
| VAPING | yes ☐ | no ☐ | quit ☐ | #day _____ | |
| Tobacco | yes ☐ | no ☐ | quit ☐ | #cigarettes/day _____ | #years _____ |
| Alcohol | yes ☐ | no ☐ | quit ☐ | #drinks per day/week _____ | type _____ |
| Drugs | yes ☐ | no ☐ | quit ☐ | _____ | |
| Exercise | yes ☐ | no ☐ | ☐ | #times/week _____ | type _____ |
| Health care proxy | yes ☐ | no ☐ | | | |
| Seat belt use | yes ☐ | no ☐ | | | |

## MEDICATIONS (including over the counter medications and supplements)

| Name | Dose |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

List any medications or foods that you are **ALLERGIC** to (and the reaction):

| | |
|---|---|
| | |
| | |

**REVIEW OF SYSTEMS** **Please circle all that are applicable (within the last 6-12 months)**

**CONSTITUTIONAL**
☐ Negative
☐ Fever
☐ Chills
☐ feeling poorly
☐ feeling tired
☐ recent weight gain
☐ recent weight loss

**EYES**
☐ Negative
☐ Eye Pain
☐ Wearing glasses
☐ spots before eyes
☐ vision changes
☐ dry eyes
☐ itchy eyes

**EAR/NOSE/THROAT**
☐ Negative
☐ Earaches
☐ Loss of hearing
☐ nose bleeds
☐ sinus problems
☐ sore throat
☐ dental problems

**CARDIOVASCULAR**
☐ Negative
☐ Chest pain
☐ Palpitations
☐ heart rate is fast
☐ heart rate is slow
☐ leg swelling (edema)

**RESPIRATORY**
☐ Negative
☐ Shortness of breath
☐ Wheezing
☐ cough
☐ dyspnea (shortness of breath) on exertion
☐ shortness of breath with lying flat (orthopnea)
☐ respiratory distress in sleep (PND)

**GASTROINTESTINAL**
☐ Negative
☐ Abdominal pain
☐ Vomiting
☐ Nausea
☐ constipation
☐ diarrhea
☐ early satiety
☐ heartburn
☐ black stool (melena)
☐ maroon colored stool (hematochezia)

**OB/GYN GU**
☐ Negative
☐ Frequency
☐ Nocturia
☐ Dysuria
☐ blood in urine
☐ cloudy urine
☐ odor in urine
☐ incomplete emptying of bladder
☐ stress incontinence
☐ urge incontinence

**OB/GYN**
☐ Negative
☐ Abnormal bleeding
☐ Irregular menses
☐ Pain with menses
☐ Pain with intercourse
☐ Anorgasmia
☐ vulvar itching
☐ midcycle bleeding
☐ post coital bleeding
☐ vulvar pain
☐ decreased libido
☐ vaginal itching
☐ pelvic pain
☐ vaginal dryness
☐ vaginal discharge
☐ vaginal odor

**MUSCULOSKELETAL**
☐ Negative
☐ Arthralgia (joint pain)
☐ joint swelling
☐ joint stiffness
☐ limb pain
☐ limb swelling

**INTEGUMENTARY (SKIN)**
☐ Negative
☐ Acne
☐ Breast discharge
☐ itching
☐ change in a mole
☐ breast pain
☐ breast lump

**NEUROLOGICAL**
☐ Negative
☐ Confused
☐ Memory problems
☐ dizziness
☐ headaches/migraines
☐ limb weakness
☐ difficulty walking

**PSYCHIATRIC**
☐ Negative
☐ Suicidal
☐ Sleep disturbances
☐ anxiety
☐ depression
☐ change in personality
☐ emotional problems

**ENDOCRINE**
☐ Negative
☐ Hair loss
☐ Hot flashes
☐ Heat/cold intolerance
☐ muscle weakness
☐ deepening of the voice
☐ feeling weak
☐ dry skin

**HEMATOLOGY/IMMUNOLOGY**
☐ Negative
☐ Easy bleeding
☐ seasonal allergies
☐ swollen glands
☐ easy bruising

**EFFECTIVE DATE APRIL, 1, 2003** **ANNISTON OB/GYN ASSOCIATES**

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.** The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from YOU, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

**For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

**For Health Care Operations.** We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

**WHO WILL FOLLOW THIS NOTICE.** This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

**POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION.** We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors, health oversight activities, inmates, law enforcement, lawsuits and disputes, military and veterans, national security and intelligence activities, organ and tissue donation, protective services for the President and others, public health risks, and worker's compensation.

## NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

**Rights to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

**Rights to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

**Right to - a - Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice any time.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

**CHANGES TO THIS NOTICE.** We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

**COMPLAINTS.** If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact our privacy officer: Christie O'Brien, **at 256-237-6755 ext. 127.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

**OTHER USES OF MEDICAL INFORMATION.** Other uses and disclosures of medical information not offered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

**I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.**

**Patient or Patient's Personal Representative** **Date**

# ANNISTON OB-GYN

Physician's Center
901 Leighton Avenue • Suite 501
Anniston, Alabama 36207
Telephone (256) 237-6755
Fax (256) 236-1823

J. Patrick Stewart, M.D., F.A.C.O.G.
Lucy K. Ballard, M.D., F.A.C.O.G.
Cynthia S. Cater, M.D., F.A.C.O.G.

Obstetrics and Gynecology

Lawrence R. Jones, M.D., F.A.C.O.G.
Cynthia M. Goldsmith-Fletcher, M.D., F.A.C.O.G.

**Our Financial Policies**

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.

2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.

3. This practice may deny service or charge a service fee for failure to pay a co-pay at the time of service.

4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.

5. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.

6. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.

7. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.

8. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

9. Medicare and Blue Cross Patients routine urine and hemoglobin ($4 each) are normally not covered when having a annual preventive exam. 3D Mammograms ($55) are not covered by all insurances. These are expected to be paid at the time of service.

★ 10. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address of file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

_____ ★ _____

Print Name Email Address

_____ _____ _____

Signature Date Date of Birth

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# E-Prescribing PBM Consent Form

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an e-prescribe program.

These include:

☐ **Formulary and benefit transactions**--Gives the prescriber information about which drugs are covered by the drug events.

☐ **Medication history transactions**—Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that **Anniston OBGYN Associates** can request and use your prescription medication history from other healthcare providers and /or third party pharmacy benefit payers for treatment purposes.

Print Patient Name: _____

Date of Birth: _____ /_____ /_____

Signature of patient: (or representative) _____

Date: _____ /_____ /_____

Relationship if other than patient: _____

Consent Denied: _____ Date: _____ /_____ /_____

# ANNISTON OB-GYN ASSOCIATES, P.C.

**901 Leighton Avenue, Suite 501**
**Anniston, AL 36207**
**(256) 237-6755**

Due to the Health Insurance Portability and Accountability Act (HIPAA), Anniston OB-GYN Associates, must inform you of how we will disclose and use your medical and account information.

In order to release medical and account information to anyone we require your written consent. Please provide the names of those persons with whom we can discuss your information below. For verification purposes, the persons named below must know your date of birth.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

## PLEASE READ CAREFULLY

Your personal information may also be given to any hospital or physician participating in your care. You may receive calls at home or work and messages may be left on an answering machine. You may also be contacted by mail regarding medical notices, statements and recall notices.

If you have any questions about this notice or would like to receive more detailed explanation of HIPAA, please contact our office.

Print Name: _____ Date of Birth: _____

Patient Signature _____ Date: _____

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I do not want my medical or account information to be discussed with anyone other than myself. I do understand that a statement will be sent to my mailing address if there are any unpaid balances.

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____