

TODAY'S DATE: _____

PLEASE PRINT

NAME: _____ AGE: _____ BIRTH DATE: _____

ADDRESS: _____ APT#: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ S.S.#: _____

EMPLOYER: _____ WORK PHONE: _____

ADDRESS: _____ SUITE: _____ CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED WIDOWED DIVORCED SEPARATED

IF APPLICABLE:

HUSBAND'S NAME: _____ AGE: _____ BIRTH DATE: _____

EMPLOYER: _____ WORK PHONE: _____ S.S.#: _____

EMPLOYER'S ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

NEAREST RELATIVE:(OTHER THAN HUSBAND)

NAME: _____ RELATION: _____

ADDRESS: _____ APT#: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

PERSON RESPONSIBLE FOR PAYMENT:

NAME: _____ PHONE: _____ RELATION: _____

ADDRESS: _____ EMPLOYER: _____

DO YOU HAVE MEDICAL INSURANCE? _____ IF SO, PLEASE LIST BELOW:

1. NAME OF INSURANCE COMPANY: _____ GROUP NAME: _____

INSURED NAME: _____ INSURED DATE OF BIRTH: _____

INSURED SS#: _____ GROUP #: _____ MEMBER #: _____

2. NAME OF SECOND INSURANCE COMPANY: _____ GROUP NAME: _____

INSURED NAME: _____ INSURED DATE OF BIRTH: _____

INSURED SS#: _____ GROUP #: _____ MEMBER #: _____

WHOM MAY WE THANK FOR REFERRING YOU TO US?

NAME: _____ ADDRESS: _____

www.cartersvilleobgyn.com

Would you like to be contacted by email? Yes No

Your email address: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. MY SIGNATURE ALSO AUTHORIZES PAYMENT OF MEDICAL BENEFITS TO HUGO D. RIBOT, M.D., TO D. MALCOLM BARFIELD, M.D., TO JEAN DAY, C.N.M., TO MACIE GOFF, C.N.M. OR TO RUTH ROSER, C.N.M. FOR ALL SERVICES PROVIDED.

(PATIENT'S SIGNATURE)

ALL PATIENTS ARE REQUESTED TO PAY BY CHECK OR CASH AT THE TIME OF THEIR VISITS. WE ALSO TAKE VISA OR MASTERCARD. PLEASE FEEL FREE TO DISCUSS OUR CHARGES.

CARTERSVILLE OB/GYN ASSOCIATES

**CARTERSVILLE PROFESSIONAL BUILDING #2, SUITE 102
958A JOE FRANK HARRIS PARKWAY
CARTERSVILLE, GEORGIA 30120
770-386-4824**

PLEASE PRINT CLEARLY

Name _____
Home Phone _____
Work Phone _____
Address _____
City _____ Zip _____
Birthdate _____
Referring Physician _____

Today's date _____
Emergency Contact _____
Home phone _____
Work Phone _____
Address _____
City _____ Zip _____

DRUG ALLERGIES

Check any medications you are allergic to:

- Aspirin
- Codeine
- Iodine
- Methergine
- Novacaine
- Penicillin
- Sulfa
- Tetracycline
- Tylenol
- Valium

Other _____

List any prescription, non-prescription, herbal or street drugs you are now using. Include antibiotics, anticoagulants/blood thinners, antihistamines, anti-seizure drugs, birth control pills, copper or progesterone IUD, narcotics, painkillers, or tranquilizers: _____

Menstrual Cycle

Do you usually have periods? Yes No
If so How often? _____
How long do they last? _____
Date of last period? _____
Age when started first period? _____
In general do you think that your periods and irregular? Yes No
Do you skip periods? Yes No
Do you have painful periods? Yes No
Describe _____

Any recent changes in pain? Yes No
Describe _____

Do you bleed between periods? Yes No
Do you ever have pain _____ or bleed _____ during or after sexual activity? Yes No
Describe _____

Pregnancy

Have you ever been pregnant? Yes No
How many births have you had? _____
Date of most recent birth _____
How many abortions and how many miscarriages have you had? _____
Have you had and complications of pregnancy? Include heavy bleeding, infection, Caesarean section, toxemia or high blood pressure. Describe _____

Are you currently breast feeding Yes No
Have you had german measles (rubella) Yes No
Are you considering getting pregnant in the next year or so? Yes No
Do you have Rh negative blood? Yes No
If so have you ever been exposed through pregnancy to Rh positive blood? Yes No
Have you ever received RhoGAM? Yes No

Pap Smear Results

Was your last Pap smear normal? Yes No
Date of last Pap smear _____
Have you ever had an abnormal Pap smear? Yes No
Date _____ Results _____
Action taken: Include repeat Pap smear, colposcopy biopsy, cauterization, etc., date and results _____

Hormone-like Drug Use

Did your mother, while pregnant with you take diethylstilbestrol (DES) ? Yes No Don't know
Did your mother take any anti-miscarriage or other drugs while pregnant with you? Yes No Don't know
List drugs _____

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Birth Control

List any birth control method you have used or are using:

Method	Dates Used	Problems/Benefits

- Thyroid problems _____ Yes No
 Skin conditions _____ Yes No
 Tumors _____ Yes No
 Cancer _____ Yes No
 Other _____

**Have you ever had any of the following conditions?
 Please note date and treatment:**

Gynecological Health Condition

- Infection of uterus, tubes,
 or ovaries (PID) _____ Yes No
 Chlamydia _____ Yes No
 Gonorrhea _____ Yes No
 Syphilis _____ Yes No
 Vaginal yeast _____ Yes No
 Vaginal Trichomonas _____ Yes No
 Vaginal bacteria infection or
 non-specific infection _____ Yes No
 Excessive uterine bleeding _____ Yes No
 Breast lumps or cysts _____ Yes No
 Herpes _____ Yes No
 Genital sores _____ Yes No
 Venereal warts _____ Yes No
 Bladder infection _____ Yes No
 Kidney problems _____ Yes No

Have you ever been hospitalized? Yes No
 If so, dates and reasons: _____

Have you ever had surgery? Yes No
 If so, dates and reasons: _____

Are you under another physician's care? Yes No
 If so, dates and reasons: _____
 Name and address of physician _____

General Health Conditions

- Ulcers _____ Yes No
 Gall bladder problems _____ Yes No
 Hepatitis or liver disease _____ Yes No
 Heart trouble _____ Yes No
 Diabetes _____ Yes No
 Epilepsy _____ Yes No
 Anemia _____ Yes No
 High blood pressure _____ Yes No
 Varicose veins _____ Yes No
 Blood clots _____ Yes No
 Lung disease _____ Yes No
 Hypoglycemia (low blood sugar) _____ Yes No
 Blurred vision _____ Yes No
 Frequent headaches _____ Yes No
 Migraines _____ Yes No

Family Health Background

- Do your blood relatives have the following?
Please note which relative.
- Cancer _____ Yes No
 Diabetes _____ Yes No
 Heart disease _____ Yes No
 Down's Syndrome _____ Yes No
 Tay-Sachs _____ Yes No
 Sickle-cell disease _____ Yes No
 Breast disease _____ Yes No
 High blood pressure _____ Yes No
 Other _____

Social History

- Do you smoke? Yes No If yes, how much? _____
 Have you ever smoked? Yes No
 Do you drink? Yes No If yes, how much? _____
 Do you use street drugs? Yes No

Patient _____ Date _____
 MD _____ Date _____
 Update _____ Date _____
 MD _____ Date _____

CARTERSVILLE OB/GYN ASSOCIATES

Patient's name _____

Date of Birth _____

ACKNOWLEDGEMENT OF HIPAA RIGHTS

I do hereby acknowledge that Cartersville OB/GYN Associates has provided me with a notice of its privacy practices, as required by Federal law (HIPAA). I understand that Cartersville OB/GYN will, upon request, provide me with a copy of the privacy policy.

Signed _____

Date _____

CONFIDENTIALITY NOTICE

It is important for us to honor the confidentiality between patient and physician. PLEASE CHECK YOUR PREFERENCE BELOW

_____ You may discuss my medical information ONLY with me.

_____ I give my permission to discuss my medical information with the following people:

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

_____ You may leave medical information (test results, appointment time, etc.) on my voice mail at:

Cell # _____

Home# _____

Cartersville OB/GYN Associates
958-A Joe Frank Harris Pkwy., Suite 102
Cartersville, GA 30120
Phone #770-386-4824 Fax#770-386-4220

Hugo D. Ribot, Jr. MD
D. Malcolm Barfield, DO
Jean Day, CNM
Macie Goff, CNM
Ruth Roser, CNM
Trina Williams, WHNP

Medical Records Authorization

Patient Name _____ Date of Birth _____

Address _____

Phone # _____ Social Security _____

I authorize Cartersville OB/GYN to **obtain** my medical records

***From:** _____

Address: _____

Phone # _____ Fax# _____

OR

I authorize Cartersville OB/GYN to **release** my medical records

***To:** _____

Address: _____

Phone# _____ Fax# _____

Circle the requested information: pap smears, operative reports, H&Ps,
biopsy reports, discharge reports, x-rays, path & lab reports, prenats, or
ALL RECORDS

Patient Signature _____

Date _____ **Witness** _____

Medical records may contain the following information:
Office notes, treatment, hospitalization, and/or care for psychological or psychiatric
impairments, drug abuse, alcoholism, contagious, communicable or venereal disease,
acquired immunodeficiency syndrome (AIDS), or test for or infection with human
immunodeficiency virus (HIV). Patients requesting medical records will be charged a fee
of \$10.00, and doctors requesting medical records require no fee.