



**PATIENT REGISTRATION FORM**

TODAY'S DATE: \_\_\_\_\_

**PLEASE PRINT**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ SS#: \_\_\_\_\_

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: \_\_\_\_\_ SS#: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**NEAREST RELATIVE: (OTHER THAN HUSBAND)**

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

**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#: \_\_\_\_\_

NAME OF PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

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 CARTERSVILLE OB/GYN ASSOCIATES 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 \_\_\_\_\_

**CARTERSVILLE OB/GYN ASSOC.**

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 CARTERSVILLE, GA 30120  
 (770) 386-4824

**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 \_\_\_\_\_

**HIPAA ACKNOWLEDGMENT FORM**

PATIENT'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

***ACKNOWLEDGMENT 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 VOICEMAIL AT:

CELL#: \_\_\_\_\_

HOME#: \_\_\_\_\_

**MEDICAL RECORDS AUTHORIZATION FORM**

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, PRENATALS, 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 VENERAL 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.