☐ **Marietta Office**
☐ **Towne Lake Office**

OB-GYN ASSOCIATES

Patient Registration Form

DATE ____/____/____

Physician (Please check one)

☐ Dr. Kelley ☐ Dr. Huffman ☐ Dr. Windom ☐ Dr. Chappell ☐ Dr. Tackitt ☐ Dr. Killian ☐ _____

When calling for today's appointment: ☐ Were you assigned one of the doctors by our receptionist, or ☐ Did you choose the doctor you wished to see

PATIENT INFORMATION

Patient Name (First, MI, Last)	Last 4 digits of Soc. Sec. # XXX - XX -	Date of Birth / /	Marital Status
Address		Apt # - Lot # - Bldg. # - C/O	
City	State	Zip Code	Primary Phone #: Home Cell ( ) -
Email Address	May we contact you by email? ☐ Yes ☐ No		Alternate Phone #: Home Cell ( ) -
Race	Circle One: Hispanic / Latino Non Hispanic / Latino		Who referred you to this practice?

***Disclaimer:** We are asking for your race and ethnicity because some people have higher risks of developing certain diseases such as high blood pressure, diabetes, and heart disease.

We will keep this information confidential (private) and will update it in your medical record. This information will assist us in continuing to provide you with quality health care. We greatly appreciate your participation.

PATIENT EMPLOYMENT INFORMATION

Employment Status: _____ Employed _____ Unemployed _____ Retired _____ Student		Circle One: Full Time Part Time
Employer Name:	Employer Phone #:	Occupation:

INSURANCE INFORMATION

Name of **PRIMARY** Insurance Company	ID #		Group #
Name of Policy Holder:	Relationship to Patient	Last 4 digits of SS # XXX - XX -	Policy Holder's DOB
Policy Holder's Employer:	Work #: ( ) -		Co-pay Amount:
Name of **SECONDARY** Insurance Company	ID #		Group #
Name of Policy Holder:	Relationship to Patient	Last 4 digits of SS # XXX - XX -	Policy Holder's DOB
Policy Holder's Employer:	Work #: ( ) -		Co-pay Amount:

EMERGENCY INFORMATION

Emergency Contact Name:	Relationship to Patient :	Circle One: Home Cell Work ( ) -

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, including Medicare, private insurance and other health plans, to this practice. I understand it is my responsibility to pay any deductible or co-insurance amount, and that I am financially responsible for all charges whether or not paid by said insurance. Finally, I will be responsible for any charges incurred due to non-notification of required insurance information necessary to process my health insurance claims.

SIGNATURE DATE

POS Reorder # 1610595

OB-GYN
ASSOCIATES

699 Church Street, Suite 300
Marietta, GA 30060

PROTECTED HEALTH INFORMATION FORM

PATIENT NAME

DATE OF BIRTH

PRIMARY PHONE NUMBER

CELL / WORK / HOME (CIRCLE ONE)

SECONDARY PHONE NUMBER

CELL / WORK / HOME (CIRCLE ONE)

MEDICAL INFORMATION AND/OR TEST RESULTS MAY BE:

☐ **GIVEN TO PATIENT ONLY**

☐ GIVEN TO THE FOLLOWING PERSON(S)

NAME RELATIONSHIP TO PT.

NAME RELATIONSHIP TO PT.

MESSAGES:

☐ MAY BE LEFT ON VOICEMAIL ☐ MAY **NOT** BE LEFT ON VOICEMAIL

SIGNATURE OF PATIENT DATE

POS Reorder # 1610597

OB-GYN ASSOCIATES

HEALTH HISTORY FORM

Patient Name _____ DOB _____ Date _____

Pharmacy Name _____ Number _____ Fax Number _____

Pharmacy Address _____ City _____

Appointment Date _____ Reason for your visit _____

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM **COMPLETELY**.

1. **VITALS:** Height _____ ft _____ in. Weight _____ lbs.
2. **DRUG ALLERGIES:** Please list ALL No Known Allergies _____

_____

Food / Environmental Allergies: _____

3. **CURRENT MEDICATIONS**

Name	Dosage	How Often per Day?

4. **PAST MEDICAL HISTORY** Patient Denies Past Medical History _____

	Date (Year)	Normal Results?	Details
Last Pap Smear	_____	☐Y ☐N	_____
Have you ever had an Abnormal Pap Smear? If yes, explain			_____
Last Mammogram	_____	☐Y ☐N	_____
Last Colonoscopy	_____	☐Y ☐N	_____
Last Dexa / Bone Density	_____	☐Y ☐N	_____

☐Y ☐N Anemia	☐Y ☐N Arthritis	☐Y ☐N Asthma
☐Y ☐N Auto Immune Disorder	☐Y ☐N Blood Disorder	☐Y ☐N Blood Transfusion
☐Y ☐N Bone Fracture	☐Y ☐N Cancer _____	☐Y ☐N Diabetes
☐Y ☐N Endometriosis	☐Y ☐N Gastric Disorder	☐Y ☐N Heart Disease
☐Y ☐N Hepatitis	☐Y ☐N High Blood Pressure	☐Y ☐N High Cholesterol
☐Y ☐N Infertility	☐Y ☐N Kidney / Bladder Problems	☐Y ☐N Seizures
☐Y ☐N Thyroid - Hyper / Hypo	☐Y ☐N Trauma / Abuse	☐Y ☐N Urinary
☐Y ☐N Uterine Fibroids		

STD's:

☐Y ☐N Chlamydia	☐Y ☐N Gonorrhea	☐Y ☐N Herpes
☐Y ☐N HPV	☐Y ☐N Syphilis	☐Y ☐N Trichomonas

Additional: _____

_____

_____

Continued on back →

5. **PAST SURGICAL HISTORY** Patient Denies any Surgeries _____

Appendix	☐Y ☐N Year _____	Bladder	☐Y ☐N Year _____
Breast Biopsy	☐Y ☐N Year _____	Breast Implants / Reduction	☐Y ☐N Year _____
C-Section	☐Y ☐N Year(s) _____	Cosmetic	☐Y ☐N Year _____
Gallbladder	☐Y ☐N Year _____	D & C	☐Y ☐N Year _____
Ovaries	☐Y ☐N Year _____	Hysterectomy	☐Y ☐N Year _____
Wisdom Teeth	☐Y ☐N Year _____	Tubal Ligation	☐Y ☐N Year _____
		Other _____	

6. **FAMILY HISTORY** Patient Denies Family History _____

Breast Cancer	☐Y ☐N _____	Colon Cancer	☐Y ☐N _____
GYN Cancer	☐Y ☐N _____	Other Cancer	☐Y ☐N _____
Diabetes	☐Y ☐N _____	Type _____	
High Blood Pressure	☐Y ☐N _____	Heart Disease	☐Y ☐N _____
Stroke	☐Y ☐N _____	Genetic Disorder	☐Y ☐N _____

7. **MENSTRUAL HISTORY**

Age at 1st period _____ Days between periods _____ Date of LAST period _____

Total days on period _____ Flow: ☐ Light ☐ Medium ☐ Heavy Clot ☐Y ☐N

Method of Birth Control _____ Breakthrough Spotting ☐Y ☐N

Menopause Status _____ Age at Menopause _____ Hormone Replacement Therapy? _____

8. **PREGNANCY DETAILS**

Total Pregnancies # _____ Full Term _____ Preterm _____ Ectopic _____

Elective Abortions _____ Spontaneous Abortions _____

Date	Birth Weight	Sex	Type of Delivery	Complications	Location

9. **SOCIAL HISTORY**

Tobacco (type & amount) _____ If Former Smoker, Date Quit _____

Alcohol (type & amount/week) _____ Occupation _____

Street Drugs (type & amount) _____ Marital Status _____

Education Level _____

SIGNATURE DATE

OB-GYN
ASSOCIATES

699 Church Street, Suite 300
Marietta, GA 30060

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A copy of the Notice of Privacy Practices of OB-GYN Associates of Marietta, LLC is posted in the lobby for my review. I am aware that I can obtain a copy of this Notice at any time.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the main waiting room area of OB-GYN Associates of Marietta, LLC.

I also understand that if I have any questions with regard to this Notice of Privacy Practices, I may contact in writing the Practice Administrator at the following address:

OB-GYN Associates of Marietta, LLC
699 Church Street, Suite 300
Marietta, GA 30060
770-425-7601 (Fax)
pmclinden@ogamarietta.com (Email)

Signature of Patient _____ Print Name _____

Date _____

OB-GYN
ASSOCIATES

FINANCIAL POLICY

Thank you for choosing our practice. Our office is committed to providing the best possible treatment and also in assisting you with insurance filing and payment of your account. In order to accomplish this in a cost effective manner, we ask that you adhere to the guidelines listed below.

1. Insurance claims for services provided will be filed and monitored by our parent company, Atlanta Women's Health Group (AWHG). AWHG will file your claim if provided with complete demographic and insurance information. If information is incomplete we are required to collect payment in full at the time of service.
2. We do not accept Medicare and/or any related Medicare Advantage plans offered through other insurance carriers. We do not file claims to Medicare or any of these related plans. Patients with Medicare are required to sign an Opt Out of Medicare Form and to pay cash for services rendered at the time of the visit.
3. We will not be responsible for non-coverage of any services as determined by your insurance carrier. It is the patient's responsibility to verify eligibility and coverage with their insurance company.
4. Most laboratory charges ordered through our office are billed separately to your insurance by either LabCorp., Quest Diagnostics or Phytest, our lab billing service. If you receive a bill from one of these companies, we ask that you contact them to resolve any question you may have.
5. We realize that OB patients' insurance plans may change over the course of the pregnancy term. We require that the patient keep us updated on those changes. Failure to provide updated information in an expedient manner may result in timeliness denials from your insurance carrier which the patient will ultimately be held responsible for.
6. All OB patients are required to pay at least 50% of the portion of the delivery fee not covered by insurance by the 1st day of the 4th month of pregnancy. The remaining 50% is due by the 1st day of the 6th month. OB patients are also required to promptly pay for any other services provided during the pregnancy. Care may be discontinued at any time for noncompliance of the above.
7. We expect you to call at least 24 hours in advance in the event you cannot make an appointment. A no show fee will be assessed based on the type of visit that was missed.

I have read and received a copy of the Payment Policy. I accept this policy for my treatment with OB-GYN Associates.

Patient Name_____ Signature _____

Date _____

POS Reorder # 1610517

OB-GYN
ASSOCIATES

FAMILY GENETIC HISTORY QUESTIONNAIRE

Name: _____ Date: _____

1. Will you be 35 years or older when the baby is due? ..... ☐ Yes ☐ No
2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders:
   - Down Syndrome (mongolism)?..... ☐ Yes ☐ No
   - Other chromosomal abnormality?..... ☐ Yes ☐ No
   - Neural tube defect, spina bifida (meningomyelocele or open spine), anencephaly? ☐ Yes ☐ No
   - Hemophilia?..... ☐ Yes ☐ No
   - Muscular dystrophy?..... ☐ Yes ☐ No
   - Cystic fibrosis?..... ☐ Yes ☐ No

   If yes, indicate the relationship of the affected person to you or to the baby's father. _____
3. Do you or the baby's father have a birth defect?..... ☐ Yes ☐ No
   If yes, who has the defect and what is it? _____
4. In any previous marriages, have you or the baby's father had a child born dead or alive with a birth defect not listed in question 2 above?..... ☐ Yes ☐ No
   If yes, what was the defect and who had it? _____
5. Do you or the baby's father have any close relatives with mental retardation? ..... ☐ Yes ☐ No
   If yes, indicate the relationship of the affected person to you or to the baby's father. _____
   Indicate the cause, if known: _____
6. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal abnormality not listed above? ..... ☐ Yes ☐ No
   If yes, indicate the condition and the relationship of the affected person to you or to the baby's father.
   _____
7. In any previous marriages, have you or the baby's father had a stillborn child or three or more first trimester spontaneous pregnancy losses? ..... ☐ Yes ☐ No
   Have either of you had a chromosomal study?
   If yes, indicate who had the results: _____
8. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sach's disease? ..... ☐ Yes ☐ No
   If yes, indicate who has the results: _____
9. If you or the baby's father are African American, have either of you been screened for sickle cell trait?
   If yes, indicate who and the results: _____ ☐ Yes ☐ No
10. If you or the baby's father is of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalassemia? ..... ☐ Yes ☐ No
    If yes, indicate who and the results: _____
11. If you or the baby's father is of Philippines or Southeast Asian ancestry, have either of you been tested for A-thalassemia? ..... ☐ Yes ☐ No
    If yes, indicate who and the results: _____
12. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? (include nonprescription drugs) ..... ☐ Yes ☐ No
    If yes, give the name of medication and time taken during pregnancy: _____
    _____

Patient Signature: _____

Reviewed by: _____ M.D.

OB-GYN ASSOCIATES
699 CHURCH STREET
SUITE 300
MARIETTA, GEORGIA 30060

To Our Patients with Medicaid Benefits:

Every Medicaid patient has to choose a Care Managed Organization (CMO) with Medicaid. There are 3 CMO's – Amerigroup, Wellcare and Peach State Health Plan. A CMO must be selected within the first 60 days of your coverage or Medicaid will automatically assign you to one of the three CMO's.

Please call Georgia Healthy Families at (888) 423-6765 and request the CMO of your choice. A postcard will be mailed to you with your CMO Identification number. Please bring that card to your next appointment.

Also, do not choose us as your Primary Care Physician (PCP) as we are a specialty physician group.

If you have any questions, please feel free to contact me at (770)422-8700, extension 4119, or by email at snorman@ogamarietta.com.

We wish you a healthy pregnancy!

Sue Norman, CPC
OB Coordinator

OB-GYN ASSOCIATES
699 CHURCH STREET, SUITE 300
MARIETTA, GA 30060

TO OUR PATIENTS WITH MEDICAID COVERAGE

This communication is to notify you that our group considers Georgia Health Partnership (Medicaid) and its contracted CMO plans (Amerigroup, Wellcare, and Peach State Health plans) to be a choice of last resort for payment of your obstetrical care. Any primary insurance carrier (i.e. Aetna, Blue Cross, United Healthcare, etc.) must be billed first according to the laws of this State, even if that coverage does not include maternity benefits.

If you knowingly do not inform Medicaid and us that you have another health insurance policy, you are committing insurance fraud. This is an illegal act that is prosecutable by law. If you have another insurance plan at this time or at any time during your pregnancy, you are required to provide us with that information.

If Medicaid pays your claims and then later demands their payment back due to another policy being the primary coverage at the date of service, you will be responsible for remitting to us the balance in full. If immediate full payment is not received, we reserve the right to commence prosecution as dictated by State law.

Please choose an option and sign below to acknowledge receipt of this notice.

- ☐ I, _____, do not have any other medical insurance coverage other than Georgia Medicaid or a contracted CMO.
- ☐ I, _____, do have other insurance and would like to provide it to you at this time.

Signed: _____

Date: _____