North Fulton OB/GYN

3400 Old Milton Pkwy, Ste C585
Alpharetta GA 30005
Ph: 770-754-4445

Patient Medical History

Please complete the following information as accurately as possible. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates. We realize this a very lengthy form, but we are asking you to provide a comprehensive history for our Electronic Medical Record which results in improved care for you.

Name:____________________ **DOB:**__________ **Date:**____________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner **SS#:**____/____/____

Address:____________________ **City:**_______________ **State:**____ **Zip:**________

Home Phone:_______________ **Work Phone:**_______________ **Cell Phone:** _______________

Occupation: ____________________ **Email:**______________________________

Preferred Method of Communication: ☐ Phone ☐ Mail ☐ E-mail

How did you hear about us? ____________________ **Referred by:**____________________

Spouse's Name: ____________________ **Spouse's Contact Phone:** _______________

Spouse's Occupation: ____________________ **Spouse's DOB:**_______________

Emergency Contact Name:____________________ **Emergency Contact Phone:** _______________

Primary Care Physician:_______________ **Phone:**____________ **Fax:**_______________

Pharmacy Name: ____________________ **Phone:**____________ **Location:** _______________

<u>Insurance Information:</u>

Primary Insurance: Carrier _______________ **Policy ID Number:** ____________________

Do you have a Secondary Insurance? (for example, under spouse or parents) ☐ **Yes** ☐ **No**

Secondary Insurance: Carrier _______________ **Policy ID Number:** ____________________

<u>Reason for Visit:</u>

What is the reason for your visit: ☐Annual exam ☐Obstetric first visit ☐Gyn Problem

If you are here for a problem what are your concerns? ____

____

____

Health Maintenance/Preventive Screening History:

Colonoscopy	□Yes □No	If yes, date / /	Results:	□Normal	□Abnormal
Dexa Scan	□Yes □No	If yes, date / /	Results:	□Normal	□Abnormal
Mammogram	□Yes □No	If yes, date / /	Results:	□Normal	□Abnormal

Pap Smear History:

Pap smear	□Yes □No	If yes, date / /	Results:	□Normal	□Abnormal
LEEP	□Yes □No	If yes, date / /	Results:	□Normal	□Abnormal
Colposcopy	□Yes □No	If yes, date / /	Results:	□Normal	□Abnormal
History of HPV?	□Yes □No	If yes, date / /			
Received HPV vaccine?	□Yes □No	If yes, date____/___/____	□Inj.1	□Inj.2	□Inj.3

Medical History:

Major illness	Yes	Major Illness	Yes
Anemia		Hepatitis ☐ A ☐ B ☐ C	
Anxiety		High blood Pressure	
Arthritis/Joint Pain		High Cholesterol	
Asthma		Hypothyroid	
Blood clot/DVT		Hyperthyroid	
Blood Transfusions		Interstitial Cystitis	
Breast Cancer		IBS (irritable bowel syndrome)	
Cancer- list type:		Jaundice	
Chronic Lung Disease		Migraines	
Depression		Osteopenia	
Diabetes Type1		Osteoporosis	
Diabetes Type 2		Ovarian Cancer	
Fibroids		Seizures	
Fracture		Sexually Transmitted Disease	
GERD		Stroke	
Heart Disease		Tuberculosis-TB	

Other:____

Past Surgical History: ☐ No past surgical history

Year	Surgery	Complications?

Current Medications: ☐ None *If there is not sufficient space please attach copy of medications list to this form. Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs:

Medication	Dosage (mg)	Frequency	Prescribing Physician

Allergies: (Food, Drugs, Environmental) ☐ **None** ☐ **Latex** ☐ **Iodine**

Allergy	Interaction	Allergy	Interaction

Family Medical History: Please indicate below significant medical problems of family members. Indicate which family member by checking the appropriate column and the AGE OF ONSET: ☐No Family History ☐Adopted

	None	Mother	Father	Brother	Sister	Grand Mother (Maternal)	Grand Mother (Paternal)	Grand Father (Maternal)	Grand Father (Paternal)	Aunt	Uncle
Blood Clots/DVT											
Breast Cancer											
Cervical Cancer											
Colon Cancer											
Diabetes											
Ovarian Cancer											
Hypertension											
Stroke											
Uterine Cancer											
Other Cancers not mentioned											
Other diseases not mentioned											

Genetic Screening: ☐ None Includes patient, baby's father, or anyone in either family

Indicate Yes or No	Yes	No		Yes	No
Tay-Sachs			Sickle Cell Disease or Trait		
Neural Tube Defect			Maternal Metabolic Disorder		
Other inherited Genetic or chromosomal Disorder			Mental Retardation/Autism		
Thalassemia			Medication/Street Drugs/Alcohol		
Hemophilia			Muscular Dystrophy		
Cystic Fibrosis			Huntington Chorea		
Down Syndrome			Congenital Heart defect		
Patient or father of the baby had/has a child with birth defects not listed			Recurrent pregnancy loss or a still birth		

Gynecology:

Age at first period:	1st day (date) of last period:
Frequency of period:	Describe Period: ☐Light ☐ Normal ☐ Heavy
Length of period:	Current Contraceptive Method:
Do you have concerns regarding your period? describe:	Are you in menopause? ☐Yes ☐ No ☐ Unsure Date of last period: Are you on hormone replacement therapy? ☐Yes ☐No

Obstetrics:

	Number		Number
Total number of pregnancies		Abortions Induced	
Full Term Births		Miscarriages	
Pre-Term Births		Living Children	

No.	Birth Date	#weeks at delivery	Sex	Birth Weight	Delivery Type	Complications	Location of Delivery
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

Social History

Are you currently sexually active? ☐ Yes ☐ No ______ If yes, what age did you become sexually active? __________

Current sexual partner (s) is/are: ☐ Male ☐ Female ☐ Male and Female

Have you had more than 5 sexual partners in a lifetime? ☐ Yes ☐ No If yes, how many?___________

Have you ever had any sexually transmitted diseases? (STDs): ☐ Yes ☐ No

If yes, what kind? ____

Are you interested in STD screening? ☐ Yes ☐ No

Do you drink alcohol? ☐Yes ☐ No If yes, ☐ Social Drinker ☐ Daily If yes, how many drinks per week? ____

Do you use recreational drugs? ☐ Yes ☐ No

If yes, what kind? ____

Do you use tobacco? ☐ Yes ☐ No If yes, Current every day __________ Current some days _________ Former______________Never______________

If current, how many cigarettes a day?____________________________ If an occasional smoker – please describe:____

BLOOD TRANSFUSION/PRODUCTS:	YES	NO	IF NO, PLEASE BRIEFLY EXPLAIN WHY.
WOULD YOU ACCEPT A BLOOD TRANSFUSION OR BLOOD PRODUCTS IN THE EVENT OF A LIFE THREATENING SITUATION?			

Please add any additional information: ____

____

AUTHORIZATION AND RELEASE:

I hereby certify that I have completed the above information to the best of my knowledge. I authorize, consent, request, and agree to actively participate in such services as routine assessments, the performance of diagnostic tests and procedures, care and treatment as self-referred or as ordered by my physician, his/her assistant or designees.

____________________________	____________________
Signature	**Date**

Please mail or fax your completed form to our office prior to your appointment. If you cannot return your form prior to your appointment, you must arrive 30 minutes early so we can enter your information into the computer. Thank you for your attention and cooperation.

NORTH FULTON OB/GYN, P.C.
Lisa Vinokur, M.D.

Permission to Verbally Discuss Protected Health Information

**Note: Completion of this form is optional. To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.*

Patient Name: ____________________________ Date of Birth: ________________

I give permission to North Fulton OBGYN to VERBALLY discuss the following medical and billing information about me (check all that apply):

__Scheduling/appointment information
__Medical information, including my symptoms, diagnosis, medications, and treatment plan. This may also include information about sexually transmitted disease (STD) testing and treatment, HIV/AIDs testing and treatment, pregnancy testing, prenatal care, birth control and family planning.
__Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan
__Chemical dependency information, including my symptoms, diagnosis, medications, and treatment plan
__Lab/test results
__Billing and payment information
__Other:____

North Fulton OBGYN has my permission to discuss the above information with:
Name:___________________________________Phone:_____________________
Relationship to Patient:_____________________

I understand that I may cancel this permission at any time, but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

This authorization expires:
_________________________ **(specify date)**
__When I cancel it in writing
__If no expiration date is specified, this authorization will remain in effect until North Fulton OBGYN Medical Records receives written notice to cancel it.

____________________________________**Signature of Patient and Date Signed**

AUTHORIZATION OF INSURANCE BENEFITS AND MEDICAL TREATMENT

I hereby give consent for medical treatment and authorize direct payment of surgical /medical benefits to Dr. Lisa A. Vinokur for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Lisa A. Vinokur to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

A photocopy of these assignments shall be valid as the original

PATIENT NAME (*please print*) ______________________________ Date ________________

PATIENT OR PARENT SIGNATURE (*if patient is a minor*) ______________________________

INSURANCE WAIVER

Our office will file primary insurance claims for you, however, office visit co-pays and deductibles are payable on the day you are seen.

Please remember it is **your** responsibility to contact your insurance company to verify that Dr. Lisa A. Vinokur is a participating physician with your particular insurance plan.

In the event that a non-covered service is performed, or non-covered lab work is ordered and performed; insurance coverage is not in effect because we are not participating in your plan; or insurance coverage is not in effect on the date of your visit; **you will be responsible for all the charges related to your office visit.**

Should you require cancellation of an appointment, please provide us with **24 hour** notice or you may be charged a **$25.00 cancellation fee.**

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

____ ____________________

Patient or Parent Signature (if patient is a minor) Date

NORTH FULTON OB/GYN, P.C.
Lisa Vinokur, M.D.

NOTICE OF PRIVACY POLICIES

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

Introduction

At North Fulton OB\GYN, P.C. we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect from you, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 4-1-03 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you contact North Fulton OB\GYN, P.C., a record of your contact is made. Typically, this record contains your symptoms, diagnoses, treatment and a plan for future care. It also contains a description of the equipment or supplies we provide for you. This information is often referred to as your health or medical record and serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed we actually provided,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Your health record is the physical property of North Fulton OB\GYN, P.C. but the information it contains belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.524
- Request amendment to your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

North Fulton OB\GYN, P.C. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures include in this authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Privacy Officer of North Fulton OB\GYN, P.C. at 770-754-4445.

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer, or with the Office for Civil Rights, U. S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights:
U.S. Department of Health and Human Services
200 Independence Avenue, S. W.
Room 509F, HHH Building
Washington, D.C. 20201

Example of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations

For example: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and other cases like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Business associates: There are some services provided in our organization through contacts with business associates. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require our business associate to appropriately safeguard your information.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Patient acknowledgement of receipt Date

NORTH FULTON OB-GYN, P.C.
Lisa Vinokur, M.D.

Annual/Yearly/Well Woman Visits

"You cannot be well and **have a problem** on the same day."

Some insurance carriers cover well woman (also known as yearly or annual) exams as a Preventative service performed once a year. This exam consists of a pelvic and breast examination, along with a pap smear.

Please check with your insurance carrier prior to your visit to inquire as to your well woman benefits. We try to verify coverage and benefits on all patients when we have received the needed information in a timely manner, however, this courtesy is not always possible due to the volume of our patients and staff time constraints.

***** If you have a ***specific problem or issue to*** be discussed, then this is **NOT** a well woman visit....these issues could include.... ***menopausal issues, PMS, birth control, pelvic pain, painful intercourse, abnormal bleeding, vaginal dryness, itching etc, if you receive a prescription for any of these issues...*** These are all possible problems or issues that will generate a diagnosis code and be considered by **your insurance company** as a sick visit – which will **then generate a co-pay**. *******

Please notify the nurse during triage if there are any concerns so that everything can be documented. If a specific problem is found during the well woman visit, you would then need to be scheduled to come back to address that issue. If enough time is available on the day of your well woman visit, your health issues could be addressed, but you may incur additional **charges** based on your insurance plan.

Please do not ask our providers or staff to change the diagnosis on your well woman exam or to omit diagnosis codes that may relate to issues discussed during the visit. Misrepresenting a diagnosis for a patient to justify services provided is fraud.

Our billing department will be happy to answer any questions you may have after you speak to your insurance carrier. Thank you for your understanding and compliance

Name: ______________________________________

Date: ______________________________________