Shelby OB/GYN P.C.

PLEASE PRINT

Please check the physician you are seeing:

__Dr. James L. Head __Dr. George M. Zaharias __Dr. E. Malcolm Simmons, III
__Dr. Jacqueline P. Hancock __ Dr. Ashley J. Duke __ Dr. Kara B. Conti

Patient Info

Patient Name: Last__________ First__________ Middle__________
Maiden Name: __________ Preferred 1st Name: __________ Age: __________
Address: __________ City: __________ State: _____ Zip: __________
Phone #'s: Home: __________ Work #: __________ Cell#: __________
Race: _____ Marital Status: __________ Birthdate: __________ **SS#:** __________
Check one: Retired___ Employed___ Full Time Student___ Part time student___
Employer: __________ Drivers license#__________
Spouse's Name: __________ Employer: __________ Phone: __________
Person to notify in case of emergency: __________ Phone: __________

Associated Party Info

Person responsible for account (**if pt under 19**): __________ DOB: __________
Address: __________
Employer: __________ Phone: __________ Drivers License#: __________
Social Security#: __________ Relationship to PT: __________

Insurance Information

Insurance Company (**Primary**): __________ **COPAY $** __________
Policy Holder's name: __________ Birthdate__________
Address: __________
Relationship to Pt: __________ SS#: __________ Employer: __________
Contract#__________ Group#__________

Insurance Company (**Secondary**) __________
Policy Holder's name: __________ Birthdate__________
Address: __________ PH#: __________
Relationship to Pt: __________ SS#: __________ Employer: __________
Contract#__________ Group#__________

I was Referred by: __________

Consent for treatment-I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, nurse or staff.
Authorization for release of information-I authorize Shelby Ob/Gyn P.C. physicians to furnish any medial information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care or my employer who is providing payment of my medical bills due to injury on the job.
Assignment of Benefits-I hereby authorize payment directly to Shelby Ob/Gyn P.C. of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but do not exceed the charges for these services. I understand that I am financially responsible for any charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverage is subject to coordination of benefits.
Guarantee of Account-For services furnished by Shelby Ob/Gyn, I hereby authorize the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama.
FINANCIAL AGREEMENT: I fully understand that I am ultimately responsible for any and all of the charges associated with my account ant that if I fail to pay any amount due, I will also be responsible for all collection fees, attorney fees, and any other charges incurred in the collection of any balance due.

PT Signature__________ Date__________

Responsible Party Signature__________ Date__________

▯ James L. Head, M.D. ▯ George Zaharias, M.D. ▯ E. Malcolm Simmons, III, M.D. ▯ Jacqueline P. Hancock, M.D. ▯ Ashley J. Duke, M.D.

Name ____________________

Date ____________ Birthdate ____________ Age ____________

What is the primary reason for your visit? ____________________

GYNECOLOGIC HISTORY

Age at first menstrual period ____________ Date of last menstral period ____________ ▯ Normal ▯ Abnormal

Are cycles regular? ▯ Yes ▯ No How many days apart? ____________ How many days do you bleed? ____________

Is amount of blood flow appropriate? ▯ Yes ▯ No Is the amount of cramping ▯ minimal ▯ mild ▯ mod ▯ severe

Date of last pap ________ ▯ Normal ▯ Abnormal Date of last Mammogram ____________ ▯ Normal ▯ Abnormal

Do you have bleeding with intercourse? ▯ Yes ▯ No

Present from of birth control: ▯ Tubal Ligation ▯ Birth Control Pills ▯ Depo ▯ Norplant ▯ Natural Family Planning
▯ Condoms ▯ Abstinence ▯ IUD ▯ Withdrawal Technique ▯ None ▯ Vasectomy

PERSONAL HISTORY

Have YOU ever been diagnosed with any of the following:

- ▯ Psychological Problems
- ▯ Depression
- ▯ Anxiety/Nerves
- ▯ Migraine Headaches
- ▯ Heart Disease
- ▯ High Blood Pressure
- ▯ Anemia
- ▯ Asthma
- ▯ MVP
- ▯ Urinary Tract Infection
- ▯ Seizures
- ▯ Liver Disease
- ▯ Diabetes
- ▯ Hypothyroidism
- ▯ Hyperthyroidism
- ▯ Breast Problems
- ▯ Endometriosis
- ▯ Genital Warts
- ▯ Genital Herpes
- ▯ Abnormal Pap Smear
- ▯ Fibroids of the Uterus
- ▯ Elevated cholesterol
- ▯ Fibromyalgia

Do you have:

- ▯ Chronic Pelvic Pain
- ▯ Pain with Intercourse
- ▯ Pelvic pressure
- ▯ Urinary leakage
- ▯ Constipation
- ▯ Hot flashes
- ▯ Vaginal discharge
- ▯ Itching
- ▯ Burning

Illness requiring hospitalization ____________________

Surgery ____________________

Serious injury or other serious illness ____________________

Drug allergies/Reactions ____________________

What medications are you taking? ____________________

OB HISTORY

Previous Pregnancies: No. of full Term Preg. ________ No. of Preterm ________ No. of Miscarriages/Abortions ________ No. of Living ________

	Month/Day/Year	Name	Sex	Weight	Vag or C/S	Anesthesia	Complications
1.							
2.							
3.							
4.							
5.							

FAMILY HISTORY

(include parents, grandparents, brothers and sisters) Do any members of your family have:

	Whom		Whom	CANCER	Whom
▯ High Blood Pressure		▯ Other Serious Disease		▯ Breast	
▯ Heart Disease		▯ Multiple Births		▯ Cervix	
▯ Kidney Disease		▯ Diabetes		▯ Ovaries	
▯ Colon Cancer		▯ Skin Cancer		▯ Uterus	
▯ Lung Cancer		▯ Leukemia		▯ Other (specify)	
		▯ Lymphoma			

PERSONAL

Occupation ____________ Married? ▯ Yes ▯ No Name of spouse or significant other: ____________

Do you smoke? ▯ Yes ▯ No How much? ________ How long? ________ Drink? ▯ Yes ▯ No How much? ________ How long? ________

Are you experiencing any personal stresses? (i.e. job change, marital discord, death of family member) about which your physician should know?

____

Is there any confidential information you would like to discuss with the physician but not write down? ▯ Yes ▯ No

GENETICS HISTORY:

Includes patient, baby's father or anyone in either family with:

	Yes	No
1. PATIENT'S AGE > 38 YEARS?	▯	▯
2. ITALIAN, GREEK, MEDITERRANEAN OR ORIENTAL BACKGROUND (MCV)	▯	▯
3. SPINA BIFIDA, MENINGOMYELOCELE OPEN SPINE OR ANENCEPHALY?	▯	▯
4. DOWN SYNDROME (MONGOLISM)?	▯	▯
5. JEWISH (TAY SACHS)?	▯	▯
6. SICKLE CELL DISEASE?	▯	▯
7. HEMOPHILIAC?	▯	▯
8. MUSCULAR DYSTROPHY?	▯	▯
9. CYSTIC FIBROSIS?	▯	▯
10. HUNTINTON'S CHOREA?	▯	▯
11. MENTAL RETARDATION, IF YES WAS PERSON TESTED * FOR FRAGILE X?	▯	▯
12. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER?	▯	▯
13. PATIENT'S OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECT NOT LISTED ABOVE. > 3 FIRST TRIMESTER SPONTANEOUS ABORTIONS OR A STILLBIRTH?	▯	▯

Patient's Signature ____________________ Date ____________

Shelby OB/GYN P.C.
Alternative People
Communication Authorization Form

Patient Name:______________________ SSN:__________

When it come to your medical treatment we strive to communicate with you in as timely and professional manner as possible. There are certain occasions when family members, friends, or others might be involved in your care as a patient and you will want our office to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of any other with whom we can discuss you care and share your protected health information.

Please list below any other people with whom you authorize our office to discuss aspects related to your care.

____ I DO NOT wish to have test results or other medical information released to anyone other than myself.

____ I DO wish to have test results or other medical information released to the following person(s) or left on my answering machine.

____ Spouse Spouse's name ________________

____ Parent Parent's name ________________

____ Answering Machine (Home Number)____________

____ Answering Machine(Work Number)____________

____ Other-Please specify Name & relationship______________

____

Patient Signature:______________________ Date:__________