Georgia Prenatal
Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.
Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com

WELCOME TO GEORGIA PRENATAL

We are thrilled that you have chosen to put your gynecological care in our hands!
We happily welcome you to our Georgia Prenatal family & care.

In order to best serve you, we need your help!
If you would please take the time to provide us with the required information & consents outlined in this packet.

Please read below as we have provided our practice guidelines & rules:

GEORGIA PRENATAL GUIDELINES & RULES

No Call, Now Shows $25
Fee *If you fail to call within 24 hours of your appointment this fee will be applied to your account. This excludes Medicaid patients.*

15 Minute Rule $00.00
Please note that if you arrive more than 15 minutes late to your scheduled appointment, you risk being rescheduled or waiting at minimum the same amount of time you were late.

COVID-19 and the Use of Masks $00.00
Due to COVID-19 and unknown omicron variants, the use of masks is optional for patients. This also applies to spouses, couples, and any other guests.

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Patient PRN #: _______________

WELCOME TO GEORGIA PRENATAL

PATIENT INFORMATION

Last Name ____

First Name ____

Date of Birth | Month ____________________ Day ___________ Year ___________ Age _______________

Social Security Number (SS#) ____________________Phone Number _______________________________

Email ____

Address | Street Number ______________ Street Name ________________________ Apt. # ____________

City __________________________________ State ____________________ Zip Code ____________________

Marital Status (Please circle one of the options below):

Single Married Divorced Life Partner Widowed

Occupation _______________________________________ Declines to Answer ____________________

Preferred Language: English Spanish Portuguese Other: ____________________

Ethnicity __________________ Declines to Answer ____________________

Preferred Method of Communication (Please circle one of the options below):

Email SMS Voice Either, No Preference

EMERGENCY CONTACT

First & Last Name ____

Mobile Phone Number _____________________ Preferred Language:______________________________

Address | Street Number ______________ Street Name ________________________ Apt. # ____________

City __________________________________ State ____________________ Zipcode _________________

Do you have Health Insurance (Please circle one of the options): Yes No

If you have Health Insurance, fill in the information below:

Name of Primary Medical Insurance: ______________________ Policy Number: ______________________

Name of Secondary Health Insurance: ______________________ Policy Number: ______________________

FINANCIAL POLICY

Our goal in Georgia Prenatal is to keep your insurance and other financial arrangements as simple and clear as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

- I authorize the release of medical information to my Primary or Secondary Insurance Company as necessary to process insurance claims, insurance applications, prior authorizations, and prescriptions.
- I also authorize payment of medical benefits to the physicians.
- I am ultimately responsible for payment of charges for services I receive in your office not covered by my insurance.
- It is my responsibility to provide the office with my current address, telephone number and insurance information.
- It is my responsibility to contact my insurance carrier to confirm that the providers participate with my plan.
- If my insurance is not Active at the time of service, I will be responsible for payment in full.
- If I do not provide correct insurance information I will be responsible for payment in full.
- Co-payment, co-insurance and / or deductible not satisfied is due at the time of service.
- Lab charges not covered by your medical insurance will be billed to you.
- Any unpaid charges after delivery will be transferred to an outside collection agency.

Please be advised all patients, with insurance and self-pay (no insurance), must disclose when the patient under our care currently has private insurance, adds private/commercial insurance or medicaid. Georgia Prenatal is not responsible for any charges accrued, nonpayment, or retro pay due to not disclosing information.

I _________________________________ understand and comply with Georgia Prenatal Financial Policy.

Signature ____ Date _______ / _______ / _______

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PREFERRED PHARMACY & CONSENT

This consent form authorizes Georgia Prenatal to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form you agree that Georgia Prenatal can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payers (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Georgia Prenatal to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Preferred Pharmacy Name ____________________________

Pharmacy Phone Number ____________________________

Address ____

Patient Name ____ Date _______ / _______ / _______

Signature ____ Date _______ / _______ / _______

Witness ____ Date _______ / _______ / _______

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PATIENT CARE & COMMUNICATION CONSENT

MEDICAL TREATMENT

Initial ________

By initialing and signing below, I authorize the providers, midwives, and nurse practitioners to treat me at the Georgia Prenatal clinic. I understand that the providers will treat me in accordance with the standards of care established by the American College of Obstetrics and Gynecology. I understand that this treatment may include laboratory tests, ultrasound, and other diagnostic procedures in order to provide me with the best care possible. All information obtained from myself by all Georgia Prenatal providers will be confidential and will remain confidential unless I sign a release of this information to another party. No one will be able to access the information in my Georgia Prenatal records without my prior written permission/consent.

PRIVACY POLICY NOTIFICATION

Initial ________

It is my understanding that Georgia Prenatal has a patient privacy notice and policy, which is available for me at any time. They have made me aware of my rights as a patient and made me a copy of their policies.

(Please circle one of the options):

I choose to receive a copy

I choose not to receive a copy

Patient Name ____ Date _______ / _______ / _______

Signature ____ Date _______ / _______ / _______

Witness ____ Date _______ / _______ / _______

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APPOINTMENT REMINDERS & GENERAL COMMUNICATION CONSENT

EMAIL Initial ______

By initialing & signing below, I am authorizing Georgia Prenatal to send me appointment reminders and practice updates via the email provided in the patient information portion of my registration.

TEXT MESSAGE Initial ________

By initialing & signing below, I am authorizing Georgia Prenatal to send me appointment reminders and practice updates via the text provided in the patient information portion of my registration. I understand that this service is offered for free of charge. However, standard text messaging rates from my mobile carrier may apply. Please activate text message reminders for my patient mobile phone number.

VOICE MESSAGE Initial ________

By initialing and signing below, I authorize Georgia Prenatal to call me and leave voice messages, at the phone number I provided in the patient information record, regarding my upcoming appointments and any other general updates related to my care.

Patient Name ____ Date _______ / _______ / _______

Signature ____ Date _______ / _______ / _______

Witness ____ Date _______ / _______ / _______

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GYNECOLOGIC HISTORY

Allergy to any medication (Please circle one of the options): Yes No

Medication name ____

Are you currently taking any medication: Yes No

Medication name ____

Reason for your visit ____

First day of your last menstrual period | Month__________ day________ Year ___________

How old were you when you first got your period ____

How long does your period last ____

How often does your period come? 28 to 30 days ______ Fewer days ______ More days ___________

Do you have pain or cramps when you get your period: Yes No | Light Moderate Severe

Do you have spotting or bleeding between your periods: Yes No | somewhat Much

Date of your last pap smear | Month__________ day_________ Year ___________

Have you had a mammogram before: Yes No

Date of your last mammogram | Month__________ day __________Year ___________

Are you sexually active: Yes No

Do you have pain or bleeding during or after sexual intercourse: Yes No

Have you had unprotected sex since your last period: Yes No

What Contraceptive Method are you using | Condoms ____ Intrauterine Device (IUD) ____ Pills ____

Injections (Depo Provera) ____ Vaginal Ring (Nuvaring) ___ Patches ___ Family Rhythm Method ____

Withdrawal Method ____ Tube Ligation _____ Vasectomy _____ Abstinence ____

Have you been pregnant before: Yes No | How many pregnancies have you had: ______________

Have you had a miscarriage: Yes No | How many miscarriages have you had: _____________

Have you had an induced abortion: Yes No | How many induced abortions have you had: ________

Have you had an ectopic pregnancy: Yes No | How many ectopic pregnancies have you had _______

Have you had vaginal deliveries: Yes No | How many vaginal deliveries ______

Have you had cesarean sections: Yes No | How many cesareans ________

Any problem urinating (leakage of urine when you cough or sneeze, etc.): Yes No _________

Check if you have had any of the following medical problems in the past or currently:

_____ Abnormal pap smear

_____ Sexually Transmitted Diseases

_____ Breast cancer or some other type

_____ Vaginal Infections

_____ Ovarian Cysts

_____ Genital Warts

_____ Surgeries on female organs

_____ Problems related to the device

_____ Diabetes

_____ Thyroid Diseases

_____ Hypertension

_____ Migraine

Do you smoke: Yes No | How often ____________________________________

Do you consume alcohol: Yes No | How often ___________________________

Have you or a member of your family been diagnosed with any of the following diseases:

____ Diabetes

____ Hypertension

____ Cancer (type of cancer ___________)

____ Hepatitis

____ HIV

_____ Migraine

_____ Thyroid disease

_____ Epilepsy

____ Fibroids

____ Asthma

____ Depression

____ Tuberculosis

____Infertility