

**MT. PLEASANT OB/GYN
PATIENT INFORMATION**

Date: _____

LastName: _____ FirstName: _____ MI: _____ PreferredName: _____

StreetAddress: _____

ZipCode: _____ City: _____ State: _____

Birthday: _____ Age: _____ Race: _____ Marital Status: _____ SS#: _____

List any phone number where we can communicate with you. This includes leaving messages (on voicemail or answering machine). These messages may be regarding upcoming appointments, lab results, etc. If you do not wish to be contacted by phone, please indicate here _____.

Home phone () _____ Work phone () _____ Cell phone () _____

Employer's Name (or School if full time): _____

Spouse or Parent's Name: _____

Spouse or Parent's Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Primary Ins. Co.: _____ PolicyHolder: _____

Policy Holder Employer: _____ Policy Holder DOB: _____

Policy Holder SS#: _____ Group#: _____

Secondary Ins. Co.: _____ Policy Holder: _____

Policy Holder Employer: _____ Policy Holder DOB: _____

Policy Holder SS#: _____ Group#: _____

Payment for services or co-pay is due when services are rendered unless previous arrangements have been made.

As a courtesy, our office will file insurance claims with contracted insurance companies. Please be advised that the services rendered may or may not be covered under your individual insurance policy. Any claims unpaid after 60 days become the responsibility of the patient.

Sign: Patient or responsible person: _____ Date: _____

I authorize the release of any medical information necessary to process any insurance claim. I authorize payment of medical benefits directly to Mt. Pleasant Ob/Gyn, PA.

Sign: Patient or responsible person: _____

MT. PLEASANT OB/GYN, P.A. — 1400 Hospital Drive, Mt. Pleasant, South Carolina 29464

NAME: _____ BIRTHDATE: _____ DATE: _____

MEDICAL HISTORY (X if positive)

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Severe headaches |
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Emotional problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Muscle problems |
| <input type="checkbox"/> Blood problems | <input type="checkbox"/> Bone problems |
| <input type="checkbox"/> Sickle Cell disease | <input type="checkbox"/> Nerve problems |
| <input type="checkbox"/> Problems with anesthesia | <input type="checkbox"/> Exposure to toxic chemicals |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> or radiation |

FAMILY HISTORY (X if positive)

- | | |
|--|---|
| <input type="checkbox"/> Cancer of breast | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer of female organs | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Other cancer | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Genetic diseases |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Other _____ | |

HABITS: Alcohol (amt.) _____ Cigarettes (amt.) _____ Other _____

HOSPITALIZATIONS AND OPERATIONS (DO NOT INCLUDE OBSTETRICAL DELIVERIES)

Date	Operation and/or Reason for Hosp.	Findings and Complications

CURRENT MEDICATIONS

ALLERGIES

Drug and Dose	Reason	Start	Stop	Drug or Substance	Reaction	Date

NAME: _____ BIRTHDATE: _____ DATE: _____

OBSTETRICAL AND GYNECOLOGICAL INFORMATION SHEET

Reason for visit:

GYN Problems - Recent (X if positive)

- _____ Vaginal discharge, odor, irritation
- _____ Sexual problems
- _____ Bleeding problems
 - _____ No menses or infrequent menses
 - _____ Irregular menses
 - _____ Heavy menses
 - _____ Abnormal bleeding or spotting
- _____ Pain
 - _____ Painful urination
 - _____ Painful intercourse
 - _____ Painful menses
 - _____ Abdominal pain
 - _____ Pelvic pain
- _____ Breast problems
 - _____ Painful breasts
 - _____ Breast lump
 - _____ Nipple discharge
- _____ Other _____

GYN History (X if positive)

- _____ Mother took DES while pregnant
- _____ Abnormal pap
- _____ Cauterization or freezing of cervix
- _____ Gonorrhea, syphilis, or chlamydia
- _____ Herpes
- _____ Severe pelvic infection
- _____ Pelvic cysts or tumors
- _____ Breast cysts or tumors
- _____ Frequent bladder infections
- _____ Rectal bleeding
- _____ Severe constipation
- _____ Chronic diarrhea
- _____ Surgery on female organs
- _____ Tubal ligation
- _____ Other _____

Date of last pap smear _____
Date of mammograms _____

MENSTRUAL HISTORY

First day of last period _____
Age at first period _____
Periods generally come every _____
days and last _____ days.
They are generally light/moderate/
heavy.

PREGNANCY HISTORY

- _____ # times pregnant
- _____ # term births
- _____ # premature births
- _____ # miscarriages
- _____ # abortions
- _____ # living children

Date of Birth	Wt.	Sex	DELIVERY RECORD		Complications	
			Length of Pregnancy	Type of Delivery (Vag., Forceps, C-section)	Maternal	Baby

BIRTH CONTROL:

Method	Brand Name	Dates of Usage	Reason for discontinuing
Birth control pills			
IUD			
Diaphragm			
Foam			
Condoms			

**MT. PLEASANT OB/GYN
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, Mt. Pleasant Ob/Gyn may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Mt. Pleasant Ob/Gyn's Notice of Privacy Practices for a more complete description of such uses and disclosures and patient rights. Copies of this notice may be found in the waiting room. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Mt. Pleasant Ob/Gyn reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Amy Warner, Privacy Officer at 1400 Hospital Drive, Mt. Pleasant, SC 29464.

With my consent, Mt. Pleasant Ob/Gyn may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Mt. Pleasant Ob/Gyn may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Mt. Pleasant Ob/Gyn restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Mt. Pleasant Ob/Gyn's use and disclosure of my Protected Health Information to carry out Treatment, Payment and Healthcare Operations.

I may revoke this in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Mt. Pleasant Ob/Gyn may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Printed Name of Patient or Legal Guardian

Mt. Pleasant OB/GYN, PA
1400 Hospital Drive
Mt. Pleasant, SC 29464-3255
(843)884-0301 Fax (843)884-9620

Delinda H. Terry, M.D., FACOG
Phyllis W. Rogerson, M.D., FACOG
Karen H. Hallmark, M.D., FACOG

Amy S. Warner, M.D., FACOG
Susanne M. Bradford, M.D., FACOG
Lauri W. Bullen, M.D.

Mt. Pleasant OB/GYN, PA Coding Notice

Mt. Pleasant OB/GYN, PA is required by law to code each appointment based on what is documented in the chart for that date of service, which may not be the same as the reason for scheduling the appointment. Once you have been seen and the visit is coded by your physician, we are unable to make changes. **We are legally bound by the documentation in your chart.** Unfortunately, this may result in your Insurance Company denying a claim you feel should have been covered. While we understand the frustration this can create we know you understand that we are only charging for the services provided as instructed by the American Medical Association Guidelines. Please direct any questions regarding this waiver to our billing office prior to being seen. The billing office phone number is 843-884-3892.

I have read this notice and understand that I am responsible for any non-covered charges from any visit I have at Mt. Pleasant OB/GYN, PA.

Signature

Date

Mt. Pleasant OB/GYN, PA
1400 Hospital Drive
Mt. Pleasant, SC 29464-3255
(843)884-0301 Fax (843)884-9620

Delinda H. Terry, M.D., FACOG
Phyllis W. Rogerson, M.D., FACOG
Karen H. Hallmark, M.D., FACOG

Amy S. Warner, M.D., FACOG
Susanne M. Bradford, M.D., FACOG
Lauri W. Bullen, M.D.

Patients Name _____ **Date** _____

1. Will you be age 35 or older when the baby is due? _____yes _____no
2. Have you had any medications or x-rays since you became pregnant?
(if yes, please list):_____ _____yes _____no
3. Has any doctor told you or your partner that you might have herpes? _____yes _____no
4. Have you or the baby's father, or anyone in either of your families ever had a baby with:
 - A. Down's syndrome (mongolism) or other mental retardation? _____yes _____no
 - B. Spina bifida, meningomyelocele (open spine)? _____yes _____no
 - C. Hemophilia? _____yes _____no
 - D. Muscular dystrophy? _____yes _____no
 - E. Hydrocephalus (water on the brain)? _____yes _____no
 - F. Cystic fibrosis? _____yes _____no
 - G. Huntington's Chorea? _____yes _____no
 - H. Congenital heart disease? _____yes _____no
 - I. Cleft lip or palate? _____yes _____no
 - J. Other known or suspected inherited or genetic conditions? _____yes _____no
5. Have you or the baby's father in previous marriage, had three or more spontaneous pregnancy losses? _____yes _____no
6. If you or the baby's father are in one or more of the following ethnic categories, please circle the appropriate category and answer the corresponding questions:
 - a. Black/East Indian: Have you or the father of baby had a sickle cell Carrier testing? _____yes _____no
 - b. Jewish: Have you or the father of he baby had Tay-Sachs carrier testing? _____yes _____no
 - c. Italian/Greek: Have you or the father of the baby had Thalassemia carrier testing? _____yes _____no
7. Are you or your husband exposed to blood or blood-products at work? _____yes _____no
8. Have you ever received a blood transfusion? _____yes _____no
9. Have you or your Husband had a history of I.V. drug abuse? _____yes _____no
10. Have you ever been screened for Hepatitis-B or AIDS? _____yes _____no
11. Do you agree to be screened for HIV (AIDS)? _____yes _____no
12. Do you have any concerns not covered by the above? _____yes _____no

Patient Signature: _____ **Date:** _____