Just For You OB/GYN

PATIENT INFORMATION

Please fill out front and back of form (PLEASE PRINT NEATLY)

Today's Date: _____

Last name (Legal) : _____ First name (Legal): _____ Middle: _____

Marital status (please circle one): Single: Married: Maiden name (or other name used if applicable): _____

Date of birth: _____ Age: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

P.O. Box Address (if applicable): _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Best way to contact you? _____

E-Mail Address: _____ Employer: _____

Occupation: _____ (circle one) Full time Part time Work phone #: _____

Student (circle one): Y N Full time student (circle one): Y N Do you need a Work / School note for today's visit?

INSURANCE INFORMATION:

NAME of PRIMARY INSURANCE COMPANY : _____

Subscriber name: _____ Date of birth: _____ Subscriber ID#: _____

Patient ID #: _____ Group # _____ Subscriber Employer: _____

Employer Address: _____ Occupation: _____

Work # _____ Patient relationship to subscriber (circle one): SELF SPOUSE CHILD Other (specify) _____

SECONDARY INSURANCE (if applicable):

NAME of SECONDARY INSURANE COMPANY: _____

Subscriber name: _____ Date of birth: _____ Subscriber ID #: _____

Patient ID # _____ Group # _____ Employer(If different than above) _____

Patient relationship to subscriber (circle one): SELF SPOUSE CHILD Other (specify): _____

PRIMARY PHYSCIAN INFORMATION

Name of Primary Care Doctor: _____ Phone #: _____

Office address: _____ City: _____ State: _____ Zip: _____

PHARMACY INFORMATION

Name of Pharmacy: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY INFORMATION

Name of LOCAL friend or relative (not living at same address is possible): _____

Relationship to patient: _____ (circle one) Female Male

Home #: _____ Cell #: _____ Work #: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? (please circle all applicable)

Doctors office Insurance plan Hospital Family Friend Close to home/work Yellow pages
Ad in paper/magazine Other: _____

Do you have family members or friends that are seen here? (circle one) Yes No If yes, who? _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Just For You Women's Healthcare OB/GYN or insurance company to release any information.

Patient / Guardian signature: _____ Date: _____

Name _____ Age _____

What is the reason for today's visit? _____

PATIENT HISTORY

When was your last pap smear?_____ Have you ever had an abnormal pap? Yes No if yes, when_____

When was your last mammogram?_____ (please circle)

PLEASE FILL OUT FRONT & BACK OF FORM – THANK YOU

Do you have /have you had any of the following medical problems? Please circle

Anemia	Yes	No
Anorexia	Yes	No
Asthma	Yes	No
Blood clots	Yes	No
Blood transfusions	Yes	No
Bulimia	Yes	No
Cancer	Yes	No
Chicken pox	Yes	No
Chlamydia	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Fibroids	Yes	No
Genital warts	Yes	No
Gonorrhea	Yes	No
Heart disease	Yes	No
Heart murmur	Yes	No
Hepatitis	Yes	No
Herpes	Yes	No
-Most recent outbreak		
High blood pressure	Yes	No
High cholesterol	Yes	No
HIV infection	Yes	No
Hypo/Hyperthyroid	Yes	No
Infertility	Yes	No
Kidney infections	Yes	No
Kidney stones	Yes	No
Lupus	Yes	No
Mitral valve prolapse	Yes	No
Osteoarthritis	Yes	No
Osteoporosis	Yes	No
Pneumonia	Yes	No
Rheumatoid Arthritis	Yes	No
Seizures	Yes	No
Stroke	Yes	No
Syphilis	Yes	No
Tuberculosis	Yes	No

Other:_____

Ob/Gyn History

First day of last period? _____ Age at first period?_____

Period comes every_____days Length of period_____days

Periods are: (circle all that apply)

regular sporadic heavy light painful

Associated with:

mood changes bloating cramps headaches

Are you sexually active? Yes No Number of lifetime partners_____

Sexual preference: men women both

What are you currently using for contraception?_____

How many times have you been pregnant?_____
How many children do you have?_____
Miscarriages?_____ Abortions?_____ Stillbirths?_____

Birth year	Weight	Sex	Type of Delivery	Complications

Have you ever had any surgery?

Type Date

_____

_____

_____

Do you take any medications?(please include vitamins,herbals)

Name Dose Frequency

_____

_____

_____

List all Allergies:_____

_____

Social History

Marital status: married single widow divorced

Do you smoke cigarettes? Yes no
If yes how many per day?_____how long?_____

Do you drink alcohol? Yes no
How much per week?_____

Do you use any other drugs? Yes no
What?_____ how often?_____

Do you feel safe in your home? Yes no

Family History

Does anyone in your family have the following conditions? If so, who

Blood clots	
Breast cancer	
Colon cancer	
Diabetes	
Heart disease	
High blood pressure	
Ovarian cancer	
Osteoporosis	
Stroke	
Uterine cancer	

Mother: Age_____ If deceased, cause of death and age_____
Father: Age_____ If deceased, cause of death and age_____

Are you experiencing any of the following:

General: Chills weight gain weight loss fatigue difficulty sleeping poor appetite

Cardiovascular: swelling of legs and feet chest pain dizzy spells fainting

Respiratory: shortness of breath wheezing cough coughing up blood

Digestive: constipation diarrhea nausea vomiting indigestion

Musculoskeletal: joint pain muscle pain weakness back pain

Genitourinary: frequent urination burning urgency

Skin: dry rash discoloration

Breasts: pain lump rash nipple discharge

Hormonal: hair loss heat or cold intolerance hot flashes change in libido excessive sweating excessive thirst

Is there anything that you are concerned about that you want the doctor to know?_____
_____
_____

JUST FOR YOU OBSTETRICS AND GYNECOLOGY,PC

PATIENT CONFIDENTIALITY

Patient Name: _____
Date of Birth: _____

Patient confidentiality is a top priority at Just For You OB/Gyn. Therefore, it is important that you provide us information to ensure then is no violation of your privacy when we attempt to communicate with you.

Please list any family members who may obtain/call/discuss your medical information:
1. _____
2. _____
3. _____

In the event that I, _____, am unable to be contacted by Just For You Ob/Gyn staff regarding lab results, test results, scheduling, surgery, procedures, messages or other sensitive health information……

_____ I give permission for this information to be discussed with the above listed family members

_____ I DO NOT give permission for this information to be discussed with anyone other than myself.

Please list all ways in which Just For You Ob/Gyn staff may attempt to contact and communicate with you. (check all that apply)

_____ Voicemail (home or cell) _____ Message at work to return call

_____ Answering machine at home _____ Mail/Postcards/Recall Cards

_____ Email _____ Fax_____ Text message _____ Other: _____

PATIENT SIGNATURE _____

DATE_____

CONSENT FOR TREATMENT

The following information is to be completed by the patient, or the patient's legally authorized representative/parent:

I consent to medical treatment for myself of for the patient for whom I am the parent or legally authorized representative. I understand that Just For You Ob/Gyn will share patient health information according to federal and state law for treatment, payment, and operations.

I understand that I must give at least a 24 hour notice when canceling any appointment. If I do not show up for an appointment three times or cancel three appointments I will be responsible for a $50 payment and Just For You has the option to quit seeing me as a patient. If I call the day of my appointment and cancel it I will be charged $50 for that date.

I understand that the patient is responsible for all changes incurred, regardless of the patient's insurance status. The patient agrees to pay for services as the patient incurs the charges. I authorize the insurance provider to pay Just For You for services rendered.

Signature of
Patient:_____Date:_____

Signature of Legally Authorized Representative:_____

Relationship of Legally Authorized Representative to Patient:_____

Date:_____

Lorie Johnson, MD, FACOG

3976 Highway 42 South, Locust Grove, GA 30248
Phone 678-814-4700 Fax: 678-814-4708

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
(previous healthcare provider)
release healthcare information of the patient named above to:

Dr. Lorie Johnson of Just For You OB/GYN

Locust Grove, Georgia 30248

This request and authorization applies to: (please check boxes)
☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.