ALPHARETTA
12389 Crabapple Road
Alpharetta, Georgia 30004

770-475-7275

www.aristaobgyn.com

1-877-893-1100

Fax: 770-475-1354

PATIENT DATA SHEET

Patient's Name_____ MM#:_____

Permanent Address (Street)_____ P.O. Box_____

City_____ State_____ Zip Code_____

Sex_____ Occupation_____ Student_____ Full-Time___Part-Time___

Patient's Phone (Home)_____ Patient's Phone (Work)_____

Patient's Cell Number_____ Patient's Pager Number_____

Patient's E-Mail Address_____

Birthdate_____ Age_____

Social Security Number_____ Driver's License_____

Marital Status M S W D SEP Handicapped? YES or NO

Employer's Name_____ Employer's Phone Number_____

Address_____ City_____ State_____ Zip_____

Spouse's Name_____

Spouse's Employer_____ Spouse's Employer Phone Number_____

Address_____ City_____ State_____ Zip_____

In Case of Emergency_____ Phone Number_____

Alternate Phone Number_____

Primary Insurance Company_____	Secondary Insurance Company_____
Address_____	Address_____
Phone Number_____	Phone Number_____
Insured Party ID#_____	Insured Party ID#_____
Group Number_____	Group Number_____
Name of Insured_____	Name of Insured_____
Sex_____ Date of Birth_____	Sex_____ Date of Birth_____
Employed By_____	Employed By_____
Relationship to Patient_____	Relationship to Patient_____

How did you hear about this practice?_____ Referring Physician?_____

NOTE: If you have lab work done, then you will receive a separate bill from the lab. Lab fees are not included in the visit.

☐ **By marking the box, I the patient, acknowledge that I have received and read a copy of the Arista OB/GYN Associates, P.C. Health Insurance Portability and Accountability Act (HIPAA).**

PATIENT'S SIGNATURE_____ **DATE**_____

ALPHARETTA
12389 Crabapple Road
Alpharetta, Georgia 30004
(770) 475-7275 Fax (770) 475-1354

CUMMING
110 North Corners Parkway, A-200
Cumming, Georgia 30040
(770) 844-0546

www.aristaobgyn.com

PATIENT CONSENT
FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

With my consent, ARISTA OB/GYN ASSOCIATES. P.C. (**ARISTA OB/GYN**) may use and disclose PROTECTED HEALTH INFORMATION (**PHI**) about me to carry out TREATMENT, PAYMENT and HEALTHCARE OPERATIONS (**TPO**). Please refer to ARISTA OB/GYN'S NOTICE OF PRIVACY PRACTICES (**NOPP**) for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices (NOPP) prior to signing this consent. ARISTA OB/GYN reserves the right to revise its Notice of Privacy Practices (NOPP) at anytime. A revised NOPP may be obtained by forwarding a written request to the ARISTA OB/GYN"S Privacy Officer at 12389 Crabapple Rd., Alpharetta, Georgia 30004.

With my consent, ARISTA OB/GYN may call my home, office and/or other locations and leave a message on voice mail, answering machine and/or directly reference me and/or any items that assist ARISTA OB/GYN in carrying out TPO, such as appointment reminders, insurance items, lab reports, hospital reports, etc.. I agree that any such call or message pertaining to my clinical care, including laboratory results may reference me personally by name.

With my consent, ARISTA OB/GYN may mail to my home or other location, items that assist ARISTA OB/GYN to carry out TPO, such as appointment reminder cards, practice marketing brochures, patient statements, etc., as long as they are marked personal and/or confidential.

With my consent, ARISTA OB/GYN may email to my home and/or other locations as per the patient data sheet. I have the right to request that ARISTA OB/GYN restrict how it uses or discloses my PHI to carry out TPO. However, ARISTA OB/GYN 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 the aforementioned uses as well as ARISTA OB/GYN'S use and disclosure of my PHI to carry out TPO. I have received a copy of the ARISTA OB/GYN Privacy Practices Policy (NOPP). I may revoke my consent in writing except to the extent that ARISTA OB/GYN has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, ARISTA OB/GYN may decline to provide treatment to me.

Signature of Patient or Legal Guardian X_____

Date:_____

Patient's name:_____

Witness:_____

ALPHARETTA
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770-475-7275 Fax 770-475-1354

Arista OB/GYN Associates, P.C.
Advanced Healthcare Services for Women

www.aristaobgyn.com
1-877-893-1100

MM: #_____

CONSENT AND REQUEST FOR MEDICAL/SURGICAL TREATMENT

Pt name_____ Date:_____ A C W

I have requested medical and/or surgical services from Arista OB/GYN Associates, P.C. (Arista OB/GYN) and by signing below I acknowledge that I voluntarily consent to treatment by Arista OB/GYN. I agree to treatment by its medical personnel including any physician and/or any other designated personnel who are under their control, who may otherwise be involved in performing such treatment or procedures; to perform said treatment, evaluation, lab tests, physical exam and/or procedures. I specifically consent to receive treatment from the Physician, Physician Assistant, Certified Nurse Midwife, Nurse practitioner or other medical personnel in the employ of, or under the control of Arista OB/GYN. I voluntarily consent to and authorize Arista OB/GYN to perform such diagnostic tests, physical exams, treatments, ultrasounds, biopsies, administration of medications, etc. and/or other tests as may be needed, necessary or desirable in the professional judgment of the attending physicians, Physician Assistants, Certified Nurse Midwives, Nurse practitioners, Ultrasonographers or other licensed personnel of Arista OB/GYN. I understand that I have the right to see or talk with the physician prior to any prescriptive drug or prescriptive device order being carried out by the Physician Assistant or other licensed midlevel provider. I am aware that the practice of medicine and surgery and obstetrics and gynecology is NOT an exact science and I acknowledge that no guarantees or assurances have been made to me as to the result of any treatment, test, diagnosis, pregnancy, surgery or outcome.

Arista OB/GYN is sometimes involved in health care education, and I agree that unless I specifically request otherwise; at times, care, examination and treatment may be delivered by students or medical personnel in training who are under the supervision of the attending physicians. Still or motion pictures of patient care may also be used for educational purposes, unless you specifically request otherwise.

Authorization for Release of Medical Information

I authorize Arista OB/GYN to release to any insurance carrier, hospital, physician, employer, government, social service agency, or to any payor or provider of medical benefits which may or will pay for any part of my medical expenses incurred, any information pertaining to my care, whether before, during or after my treatment, for the purpose of evaluating and processing claims for my care at Arista OB/GYN. I further authorize Arista OB/GYN to disclose information regarding my care to the designated utilization review or peer review organization or committee of my insurer, employer or other payor or provider of medical benefits, and to such other parties as may be necessary to effectuate payment for my care. I authorize the release of my medical records to other physicians, hospitals, governments, ambulatory surgery centers, medical practices, health departments or other institutions for the purpose of continuing care and/or transfer of my care.

I acknowledge and understand that Arista OB/GYN may be required to submit certain reviews of the care of patients to accrediting and licensing agencies and to other such persons as may require access to the medical information or the medical record.

I understand the medical record is the property of Arista OB/GYN and that I may obtain a copy of my medical record in accordance with the policies and procedures of Arista OB/GYN and the laws of the State of Georgia. I understand that I will be required to pay the charges for reproduction of the medical record, if a copy of any portion of the record is requested, faxed, mailed, emailed or digitally copied.

I understand that if the physician determines that disclosure of the medical record will be detrimental to my physical or mental health, then Arista OB/GYN may refuse to furnish the record to me. I authorize Arista OB/GYN to release any information acquired in the course of my examination and/treatment including, but not limited to, confidential information related to psychiatric care, drug and alcohol abuse, sexually transmitted diseases and human immunodeficiency syndrome and complex (HIV/AIDS).

I hereby authorize and direct payment to Arista OB/GYN for the surgical and/or medical benefits otherwise payable to me under the terms of my insurance coverage. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by my insurance company, unless otherwise provided by the terms of an agreement between the insurance company and Arista OB/GYN. I understand that if certification is denied then benefits may be withheld and I will be responsible for the charges.

I understand that to protect myself from unnecessary financial losses, I must review my obligations with my insurance company, utilization review programs and the company benefits coordinator.

I hereby authorize any physician, hospital, or medical care facility to provide any and all information on my medical history and treatment to Arista OB/GYN. I agree that this authorization will cover all medical and/or surgical services rendered. I authorize photocopies of this form to be as valid as the original.

I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED OR EXPLAINED IN A SATISFACTORY MANNER. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ OR HAD IT READ OR EXPLAINED TO ME AND I UNDERSTAND THIS FORM AND I VOLUNTARILY CONSENT TO ALLOW ARISTA OB/GYN OR ANY PHYSICIANS DESIGNATED OR SELECTED BY IT AND ALL MEDICAL PERSONNEL UNDER THE DIRECT SUPERVISION AND CONTROL OF SUCH PHYSICIANS AND ALL OTHER PERSONNEL WHICH MAY OTHERWISE BE INVOLVED IN PERFORMING SUCH PROCEDURES, TO PERFORM THE PROCEDURES, TREATMENTS AND SERVICES DESCRIBED ABOVE OR OTHERWISE REFERRED TO HEREIN.

Patient signature_____ DATE:_____ Form front: 2013-0404

ARISTA OB/GYN **GYNECOLOGIC INTAKE HISTORY** **MEDMGR #**

NAME: _____ DATE: ____/____/____

ADDRESS: _____ BIRTH DATE: ____/____/____

CITY: _____ HOME TEL: ( ) _____

STATE/ZIP _____ WORK TEL: ( ) _____

EMPLOYER: _____ INSURANCE: _____

NAME OF SPOUSE/PARTNER _____ REFFERRED BY: _____

REVIEW OF SYSTEMS: PLEASE CHECK (√) ANY BOXES THAT APPLY TO YOU NOW OR HAVE APPLIED IN THE PAST

	Currently	Past	Notes
1. Constitutional			
Weight loss	☐	☐	
Weight gain	☐	☐	
Fever	☐	☐	
Fatigue	☐	☐	
2. Eyes			
Double vision	☐	☐	
Spots before eyes	☐	☐	
Vision changes	☐	☐	
3. Ears/Nose/Throat/Mouth			
Ear aches	☐	☐	
Ringing in ears	☐	☐	
Sinus problems	☐	☐	
Sore throat	☐	☐	
Mouth sores	☐	☐	
Dental problems	☐	☐	
4. Cardiovascular			
Painful breathing	☐	☐	
Chest pain	☐	☐	
Difficult breathing on exertion	☐	☐	
Swelling of legs	☐	☐	
Palpitations of heart	☐	☐	
5. Respiratory			
Wheezing	☐	☐	
Spitting up blood	☐	☐	
Shortness of breath	☐	☐	
Chronic cough	☐	☐	
6. Gastrointestinal			
Frequent diarrhea	☐	☐	
Blood stool	☐	☐	
Nausea/vomiting	☐	☐	
Constipation	☐	☐	
7. Genitourinary			
Blood in urine	☐	☐	
Pain with urination	☐	☐	
Urgency	☐	☐	
Frequency of urination	☐	☐	
Incomplete emptying	☐	☐	
Stress incontinence	☐	☐	
Abnormal periods	☐	☐	
Painful intercourse	☐	☐	
8. Musculoskeletal			
Muscle weakness	☐	☐	
9. Skin/Breast			
Pain in breast	☐	☐	
Discharge	☐	☐	
Masses	☐	☐	
Rash	☐	☐	
Ulcers	☐	☐	

REVIEW OF SYSTEMS (CONTINUED) PLEASE CHECK (√) ANY BOXES THAT APPLY TO YOU NOW OR HAVE APPLIED IN THE PAST			
	Currently	Past	Notes
10. Neurological			
Dizziness	☐	☐	
Seizures	☐	☐	
Numbness	☐	☐	
Trouble walking	☐	☐	
11. Psychiatric			
Depression	☐	☐	
Frequent crying	☐	☐	
12. Endocrine			
Dry skin	☐	☐	
Abnormal thirst	☐	☐	
Hot flashes	☐	☐	
13. Hematologic/lymphatic			
Frequent bruises	☐	☐	
Cuts that do not stop bleeding	☐	☐	
Enlarged lymph nodes	☐	☐	
14. Allergic/immunologic			
Allergies	☐	☐	
Drug allergy	☐	☐	

Personal Past History PLEASE CHECK (√) ANY BOXES THAT APPLY TO YOU NOW OR HAVE APPLIED IN THE PAST					
MAJOR ILLNESSES	YES	NO	MAJOR ILLNESSES	YES	NO
Asthma	☐	☐	Cancer	☐	☐
Pneumonia	☐	☐	Ulcers	☐	☐
Chronic Lung Disease	☐	☐	Depression/anxiety	☐	☐
Kidney Infections/stones	☐	☐	Anemia/Blood transfusions	☐	☐
Tuberculosis	☐	☐	Seizures/convulsions/epilepsy	☐	☐
Venereal Disease	☐	☐	Bowel trouble	☐	☐
Heart Trouble/murmur	☐	☐	Glaucoma	☐	☐
Diabetes	☐	☐	Arthritis/joint pain	☐	☐
High Blood Pressure	☐	☐	Fracture	☐	☐
Stroke	☐	☐	Hepatitis/Yellow jaundice	☐	☐
Rheumatic Fever	☐	☐	Thyroid Disease	☐	☐

OPERATIONS/HOSPITALIZATIONS (DESCRIBE REASON FOR OPERATION/HOSPITALIZATION)			
	Date		Date

INJURIES/ILLNESSES (DESCRIBE TYPE OF INJURY/ILLNESS)			
	Date		Date

LAST IMMUNIZATION OR TEST			
	Date		Date
Tetanus		Pneumonia	
Flu Shot		TB Skin Test	

OB/GYN HISTORY			
	Number		Number
Births		Abortions	
Miscarriages		Living children	

CURRENT MEDICATIONS (LIST DRUG NAME[S] AND DOSAGE[S])			
	Dosage(s)		Dosage(s)
Will you accept a blood transfusion? ☐Yes ☐ No		Arista OB/GYN 12389 Crabapple Rd Alpharetta,GA 30004 770-475-7275	

FAMILY HISTORY: PLEASE CHECK (√) YES IF A FAMILY MEMBER HAS OR HAD ONE OF THESE ILLNESSES

Illness	Yes	No	Family Member	Illness	Yes	No	Family Member
Diabetes	☐	☐		Drinking Problem	☐	☐	
Stroke	☐	☐		Breast Cancer	☐	☐	
Heart Disease	☐	☐		Colon Cancer	☐	☐	
High Blood Pressure	☐	☐		Ovarian Cancer	☐	☐	

SOCIAL HISTORY: PERSONAL HABITS

	Yes	No		
Smoking	☐	☐	Packs per day: _____	Years: _____
Alcohol	☐	☐	Drinks per day: _____	Drinks per week: _____
Drug Use	☐	☐		
Seat Belt Use	☐	☐		
Regular Exercise	☐	☐		

PERSONAL PROFILE

Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐

Number of Living Children _____

Number of people in household _____

School Completed High School ☐ College ☐ Graduate Degree ☐ Other ☐

Current or most recent job _____

PERSONAL SAFETY	YES	NO
Has anyone close to you ever threatened to hurt you?	☐	☐
Has anyone ever hit, kicked, choked, or hurt you physically?	☐	☐
Has anyone, including your partner, ever forced you to have sex?	☐	☐
Are you ever afraid of your partner?	☐	☐

MEDICARE "HIGH RISK" CRITERIA: Please check (√) if you have ever been treated for any of the following infections:

Vaginosis	☐	Genital Warts	☐	Chlamydia	☐
Trichomonas	☐	Gonorrhea	☐	Syphilis	☐

	YES	NO	
Have you had a Pap smear in the last 7 years?	☐	☐	
Have you ever had an abnormal Pap smear test?	☐	☐	If so, when? _____
Did you begin sexual activity before you were 16 years old?	☐	☐	
Have you had more than 5 sexual partners in your lifetime?	☐	☐	
Have you ever tested positive for the HIV virus?	☐	☐	
Did your mother take the drug DES when she was pregnant with you?	☐	☐	

Completed by: Patient ☐ Office Nurse ☐ Physician ☐

Signature of patient: _____

Date reviewed by physician with patient: _____

Physician Signature: _____

Annual Review of History:

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____