Exam Date

PIEDMONT GYNECOLOGY & OBSTETRICS, P.C.

Identification Data

Name

Name you prefer to be called

Address

City State Zip Code

Country

Home Telephone Number

Cell Phone Number

Date of Birth

E-mail Address

Age Marital Status

Religious Preference SSN

Referred By

Occupation

Employer

Phone Number

Preferred Phone Contact

Spouse/ Partner

Name

Occupation

Employer

Best Contact Phone Number

Social Security #

Date of Birth

Next of Kin Not At Same Address

Name

Address

City State Zip Code

Relationship

Phone Number

Country

Whom May We Contact If Necessary (If Other Than the Above)

Name

Address

City State Zip Code

Relationship

Phone Number

Country

Insurance Information

Primary Insurance Company

Contract or ID Number Group Number

Secondary Insurance Company

Contract or ID Number Group Number

PIEDMONT GYNECOLOGY & OBSTETRICS, P.C.
2001 Peachtree Road NE, Suite 435
Atlanta, Georgia 30309

ANNUAL VISIT PATIENT INFORMATION

Name ______ Exam Date ______

Have you experienced non-gynecological problems for which you have consulted other doctors since your last visit?
☐ Yes ☐ No If yes, what problems, and whom did you consult? ______

Are using the same contraceptive method (and, if it is the pill, the same pill) as at your last visit? ☐ Yes ☐ No

Any new allergies? ☐ Yes ☐ No If so, what: ______

Any new cases of breast cancer in your family? Mother/ Sister ☐ Yes ☐ No If yes, who? ______

Are there any changes in your personal circumstances (e.g., job, marriage) about which we should know?
☐ Yes ☐ No Use space to answer question ______

Are you having any health problems that need to be addressed at this visit?
☐ Yes ☐ No If yes, please specify: ______

Please do not write below this line.

EXAM

Age ______ F ______ P ______ A ______ L ______ LNMP ______ Contraception ______

Last Pap ______ Result ______ Wt. ______ Change ______ Ht ______ BMI ______ BP___ /___

Thyroid
Chest
Breast
Abdomen
Ext Gen
Vagina

Cervix
Uterus
Adnexa
Ovaries
Rectal

Hgb ______ U/A Alb ______ Glu ______ Cholesterol ______ Hemoccult ______

Decision: ☐ S ☐ LC ☐ MC ☐ HC

Severity: ☐ MI ☐ LS ☐ MS ☐ HS ☐ SR ☐ RP ☐ SC ☐ UE ☐ LT

Time: ______

DO NOT WRITE IN THIS SPACE

Annual Exam

Name

Exam Date

M.D. Comments

Assessment

Plan

PIEDMONT GYNECOLOGY & OBSTETRICS, P.C.

2001 Peachtree Road NE, Suite 435
Atlanta, Georgia 30309

MEDICATION LIST

Name

Exam Date

Known Allergies

Please list below all medications you take on an ongoing basis, as well as anything you are taking temporarily (like an antibiotic for a bladder infection).

Please include non-prescription medicines (like aspirin, vitamins, or calcium) and any herbal medicines or nutrition supplements.

Medications you are currently taking	Strength (Dosage)	How often taken	Doctor's Comments

Piedmont Gynecology & Obstetrics, P. C.

John B. Pugh, M.D.

Name ______ Exam Date ______

Please take a few moments and fill out this form as completely as you can.

Main reason for seeking medical attention ______

☐ No Complaint. Desire a periodic examination.

AUTHORIZATION

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/ AIDS-confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby assign and authorize payment to Piedmont Gynecology & Obstetrics, P.C. of all medical and/ or surgical benefits, including major medical benefits, to which I am entitled under any insurance policy or policies, under any self-insurance program, or under any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Piedmont Gynecology & Obstetrics, P.C. by any insurance policy, self-insurance program or other benefit plan.

☐ My insurance requires a co-pay.

☐ My insurance requires a deductible

The amount of my deductible is ______

I agree that I will pay any amount not paid by my insurance within 30 days of the receipt of a statement.

______ Exam Date ______

Person providing the authorization

______

Relationship to patient if not patient

Piedmont Gynecology & Obstetrics, P. C.

John B. Pugh, M.D.

Preventative Screening Questionnaire

Please fill out the following information related to your health.

Check all boxes that apply to you.

Name: ______ Current Date ______

Who is your primary physician? Name: ______

Address ______ Telephone ______

Pneumonia Vaccination (if you are 65 or older):

- ☐ I have received a pneumonia vaccination. Approximate Date: ______
- ☐ I have not received a pneumonia vaccination
- ☐ I would like information on the pneumonia vaccination.

Tobacco Use (all patients):

- ☐ I currently use tobacco.
- ☐ I currently do not use tobacco.
- ☐ I would like information and assistance quitting.

Colon Cancer Screening (if you are 50 or over)

- ☐ I have been tested for colon cancer (colonoscopy). Approximate Date: ______
- ☐ I have never been tested for colon cancer.
- ☐ I would like information on colon cancer screening.

Breast Cancer (if you are 40 or over):

- ☐ I have had a mammogram in the past two years. Approximate Date: ______
- ☐ I have not had a mammogram in the past two years.
- ☐ I have a family history of breast cancer.
- ☐ I would like information on breast cancer screening.

PIEDMONT GYNECOLOGY & OBSTETRICS, P.C.
John B. Pugh, M.D.

Financial Policy

We are committed to meeting your health care needs with the highest quality of care. In order to keep financial arrangements as simple as possible, we have implemented the following guidelines:

1. You are ultimately responsible for payment of charges for services you receive from our office. Any check payment not honored by your bank may result in a $35.00 returned check charge.

2. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit.

3. If you are unable to provide us with current insurance information (i.e., a current insurance card or written documentation of coverage from your insurance carrier), you will be required to pay for any services you receive. When you have provided us with the insurance information, we will file a claim with your insurance carrier and reimburse you once we have received their payment.

4. It is your responsibility to contact your insurance carrier to confirm that our office participates in your plan. If you receive services from our office and we are not on your plan, you will be responsible for payment in full of our fee(s).

5. All co-pays are due at the time of service. A $25.00 service fee may be charged for failure to pay the co-pay at the time of the service.

6. We use Piedmont Hospital, LabCorp or Quest for all laboratory services. If your insurance requires us to use another lab (such as LabOne), it is your responsibility to let us know at the time of the visit.

7. All medical records requests must be submitted in writing and received in our office ten (10) work days prior to the date needed. This request requires your signature and the complete name and address where the records are to be mailed. We will fax five (5) pages or less provided the fax number is provided with your request.

Items 8 and 9 address problems that affect the efficiency of the office and overall patient services. We will be very pleased if we never have an occasion to apply any of these fees.

8. We charge a fee of $50.00 for each appointment missed, cancelled or rescheduled if our office is not contacted 24 hours or more prior to your appointment time. Only with a minimum of 24 hours notice can we make the appointment time available to another patient. **There are no exceptions to this policy; please do not ask.**

9. Due to increasing regulations and insurance requirements, the volume of our administrative paperwork increased dramatically. These costs cannot be recovered by a fee increase because insurance reimbursement rates are not linked to our fee schedule. Because of this increase in overhead, we can no longer provide specific administrative services free of charge as we have done in the past. We will require a pre-paid $25.00 fee for the completion of forms including, but not limited to: marriage license, foreign travel, family medical leave, disability, life, adoptions, camp, letters or other administrative forms required by parties other than your insurance company, other miscellaneous letters or forms requested.

We will require a pre-paid $25.00 fee for a patient requested computer generated report such as payment history, extra claims, etc.

We will charge a per page fee for any records requested to be sent to the patient.

____
Signed By

Printed Name

Exam Date

Please Initial