Patient Name: ____

Confidential Communications

I hereby request to receive confidential communication from ACOOG in the following manner:

1. Telecommunications/E-mail:
   - ☐ Web enable this account using ACOOG's patient portal.

   Please leave messages as follows (check all that apply):

   - ☐ Home Phone **Brief or Extended** ☐ Cell Phone **Brief or Extended**
   - ☐ Work Phone **Brief or Extended**
2. Postal Communications:

   Please mail my protected health information to me at (select only one):

   ☐ Mailing Address on file ☐ Other as follows

   Address:_________________________ City:_______________ State:_____ Zip:________
3. Emergency contact as listed on page one (1) of this form
4. Additional Contact - In your absence who can we leave protected health information with?

   Name:_________________________ Relation:_______________ Phone # _______________

Notice of Privacy Practices

I understand ACOOG will notify me if ACOOG is unable to comply with my request. I also understand that my protected health information may be released as my physician determines appropriate in an emergency situation. I have received the Notice of Privacy Practices at Associates in Central Ohio OB/GYN, Inc. (ACOOG). ☐ **Yes** ☐ **No** **Initials** ________

Insurance Assignment and Acknowledgement:

I understand my insurance carrier can choose to assign benefits to Associates in Central Ohio OB/GYN, Inc. or my insurance carrier may make payment directly to me. I understand and certify I am financially responsible for all health care service charges that are paid to me directly by me insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charge for non-covered service provided to me or to any of my dependents. I am also responsible for providing up-to-date and accurate insurance information for each visit. We file claims directly to primary insurance only (exception: secondary government plans). Upon request we will provide a claim form for you to file with your secondary insurance carrier. If you are required to have a referral for your appointment, please be sure to bring it to your appointment.

If we are not participants in your insurance plan, upon request, our billing office will provide you with an itemized claim form to file with your insurance carrier for reimbursement. However, payment is expected in full at time of service. ***Billing#614-923-0153.***

Medicare and Medicaid: *I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.*

I authorize any holder for medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, and/or its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and payment.

I acknowledge I was given an opportunity to decline to have my information exchanged through the Offerings which rely upon the Record Locator Service ("opt-out"). If I choose to opt out, all notifications will be turned off.

We require a 24 hour cancellation notice. Failure to due so will result in a $52 no show fee after first occurrence. If you fail to make payment in full for services rendered to you, your outstanding balance will be placed with our collection attorney.

By signing below, I certify I will pay to Associates in Central Ohio OB/GYN, Inc. any co-payments, co-insurance, deductibles or non-covered services. I understand the ACOOG does not accept post-dated checks. I will immediately pay to Associates in Central Ohio OB/GYN, Inc. any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by insurance for my failure to provide that appropriate insurance information for billing.

______________________	______________________	______________________
Patient Printed Name (if 18 and older)	Patient Signature (if 18 or older)	Date Signed
______________________	______________________	______________________
Guarantor Printed Name (if applicable)	Guarantor Signature (if applicable)	Date Signed

Patient Name________________________________ Age__________ DOB____________________

Review of Symptoms: (circle all that apply)

Please indicate if you currently or frequently have any of the following

Menses:

1st day of last period _____/_____/_____ Regular Irregular Absent

Flow: Heavy Light Normal Spotting

Frequency: <28 days >28 days Every 28 days

Painful Periods? No Yes

Planning pregnancy within the year? No Yes

Using birth control? No Yes

If yes what method? ______________________

Breasts:

Discharge?	No	Yes	Left	Right
Lumps?	No	Yes	Left	Right
Pain?	No	Yes	Left	Right
Do you do self-breast exams?			No	Yes

Have you ever had:

Mammogram?	No	Yes	Date of service?_______
Colonoscopy?	No	Yes	Date of service?_______
Bone Density?	No	Yes	Date of service?_______

Postmenopausal: Yes No Age: ________ Year:_________

Postmenopausal type: Bilateral oophorectomy Chemo induced Drug Induced Hysterectomy w/BSO Natural Premature

Hormone Replacement Therapy: Estrogen Estrogen/Progesterone Progesterone Testosterone

Menopausal Symptoms? None

Hot flashes

Insomnia

Night Sweats

Vaginal Dryness

Additional Symptoms: No associated symptoms

Abnormal bleeding	Nocturia (urinating at night)
Anxiety	Sexual dysfunction
Decreased Libido	Sleep disturbances
Depression	Urinary incontinence
Difficulty falling asleep	Urinary urgency
Dyspareunia (pain with sex)	Vaginal discharge
History of Infertility	Vaginal itch

Other: ______________________

Exercise No Yes

Days per Week ________________

If under the age of 45, have you completed the Gardasil series for HPV? Yes No

If no, are you interested? Yes No

Medications, Vitamins: ____

____

Drug/Food Allergies and Reactions: ______________________________________

Preferred Pharmacy:______________________ Pharmacy Phone:__________________

Medical /Surgical History

Any changes in medical history since last year (std, HTN, psych, etc.)____________________

New Surgeries since last year______________________________________

New pregnancies (abortions, miscarriages, etc.) ______________________________

Family History:

Please list your family members who have had any of the following using the follow abbreviations.

M=Mother, F=Father, S=Sister, B=Brother, MGM=Mother's mother, MGF=Mother's father, PGM=Father's mother, PGF=Father's father, PU=Paternal uncle, MA= Maternal aunt

_________Breast cancer	_________Colon cancer	_________High Blood Pressure	_________Liver disease
_________Ovarian cancer	_________Heart attack	_________Diabetes	_________Osteoporosis
_________Uterine cancer	_________Stroke	_________Thyroid problems	_________Blood clot
_________Cervical cancer	_________High cholesterol	_________Depression	(leg or lung)

Social History:

Smoking: Never Former Smoker Current Smoker _________packs per day or week

Alcohol: None **Type** Beer Wine Liquor **Frequency** Day Week Month **Amount** _________(#of glasses)

Caffeine: None **Type** Coffee Tea Soda Chocolate Energy drinks **Amount per day**___________(#of glasses)

Race:________________________________ Ethnicity:______________________________

Primary Language Spoken:___________________ Language Spoken at home:___________________

Marital Status: Married Single Divorced Separated Widow Life Partner

Religion:___________________________ History of Sexual Abuse:____________________

Illegal Drug Use: No Yes Type:_______________ Sexual Preference Men Women Both Neither

RISK ASSESSMENT FOR HEREDITARY CANCER SYNDROMES

Patient Name: ______________________ Provider Name: ______________________
Date of Birth: ______________________ Today's Date: ______________________
Reason for Today's Visit: ______________________ Insurance Company: ______________________

This is a screening tool for cancers that run in families. Please consider the following family members:
Yourself/Mother/Father/Sister/Brother/Children Aunt/Uncle/Grandparent/Niece/Nephew
Cousin/Great Grandparent

In the boxes provided, write the relative and estimate the age of diagnosis for each statement that applies to you or your family. FOR EXAMPLE: Dad's sister (an aunt) had breast cancer at age 48.

FAMILY HISTORY OF CANCER			SELF	WHICH FAMILY MEMBER (consider parents, children, siblings, aunts/uncles, cousins, nieces/nephews, grandparents, or great grandparents)	
				MOTHER'S SIDE	FATHER'S SIDE
(Y)	N	*EXAMPLE: Breast cancer* ***BEFORE AGE 50***	-----	-----------------	*Aunt, age 48*
Y	N	Ovarian cancer **AT ANY AGE**			
Y	N	Breast cancer **BEFORE AGE 50**			
Y	N	2 or more breast cancers on the same side of the family **AT ANY AGE**			
Y	N	Male breast cancer **AT ANY AGE**			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian, or pancreatic cancer **AT ANY AGE**			
Y	N	Colorectal or uterine (endometrial) cancer **BEFORE AGE 50**			
Y	N	3 or more colorectal or uterine (endometrial) cancers, **AT ANY AGE**			

FOR OFFICE USE ONLY

- ☐ Patient meets criteria for genetic testing: ☐ YES ☐ NO
- ☐ Patient was offered genetic testing today: ☐ YES ☐ NO
- ☐ Patient **DECLINED** recommended genetic test: ☐ YES ☐ NO
- ☐ Appointment for Test Result Consult is scheduled on: ______________________

Healthcare Provider Signature: ______________________

If patient **DECLINED** genetic testing, patient signature: ______________________