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 Only Estrogen/Progesterone
Progesterone Only Testosterone

Menopausal Symptoms? None
Hot flashes
Insomnia
Night Sweats
Vaginal Dryness

Additional Symptoms: No associated symptoms

Abnormal bleeding
Anxiety
Decreased Libido
Depression
Difficulty falling asleep
Dyspareunia (pain with sex)
History of Infertility
Nocturia (urinating at night)
Sexual dysfunction
Sleep disturbances
Urinary incontinence
Urinary urgency
Vaginal discharge
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 any **updates** to your **family** history since you last annual exam (Cancers, high blood pressure, diabetes, osteoporosis, blood clots, etc.) using the following 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

Family Member:	Diagnosis:

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 Orientation: Straight/Heterosexual Lesbian/Gay/Homosexual Bisexual Other:_____

Personal Pronouns: She/Her/Hers He/Him/His They/Them/Theirs

Risk assessment for hereditary cancer syndromes

Patient name: _____ Patient date of birth:_____

Have you had BRCA or other cancer genetic testing in the past (check one)?

_____ Yes (date_____) If so, you don't have to continue filling out this form.

_____No. Please continue.

For the following questions, please consider the following individuals: Yourself, mother, father, sister, brother, cousin, aunt, uncle, grandparents, niece, nephew, great grandparents.

Family history of Cancer			**Mother's side (who and what age)**	**Father's side (who and what age)**
Yes	No	Example	Self age 30, Aunt age 40, cousin age 20	
Yes	No	Ovarian Cancer		
Yes	No	Breast cancer **before age 50**		
Yes	No	Two or more breast cancers on the same side of the family		
Yes	No	Male breast cancer		
Yes	No	Ashkenazi Jewish ancestry **AND** breast, ovarian or pancreatic cancer		
Yes	No	Colorectal or uterine (endometrial cancer) **before age 50**		
Yes	No	Three or more colorectal or uterine(endometrial) cancers on the same side of the family		

Office use only:
Meets criteria for genetic testing? Yes No
If yes, please check one:
_____Affected family member tested negative, testing not indicated.
_____Genetic test today.
_____Patient to consider (Brochure given: Yes No).
_____Referral sent for genetic counselling.
_____Other: _____

Provider signature: _____