ATLANTA PREMIER OB/GYN ASSOCIATES

Date:________________ SSN:____________________ D.O.B.____________________

Patient Name________________________________ Phone ____________________

Address_____________________________ City_________ State_______ Zip_______

Marital Status______________ Email____

Employer_______________________________________ Phone___________________

Primary Insurance Company ____

Primary Care Physician ____

WHO SHOULD WE THANK FOR YOUR REFERRALL? ________________________________

In Case of Emergency who should we contact?

Name ____ Phone _________________

Medical Records Release Authorization

I authorized Atlanta Premier OB/GYN Associates, PC to release to my insurer any medical information necessary to obtain payment of medical benefits under my health insurance.

Benefit Assignment Authorization

I authorize my insurer(s) to pay Atlanta Premier OB/GYN Associates, PC any medical benefits due to me or my dependents under health insurance services rendered by Atlanta Premier OB/GYN Associates, PC.

Financial Obligation Acknowledgement

I understand that I am responsible to pay Atlanta Premier OB/GYN Associates, PC for services rendered to me or my dependents if payment of assigned benefits under my health insurance is denied or not paid with a reasonable length of time by my insurer(s)

Authorized Signature____________________________ Date__________________

Medicare Advance Beneficiary Notice (ABN)

I have been informed that Medicare will only pay for services deemed to be "reasonable and Necessary" under section 1862(a) (1) of the Medicare Law. In the event Medicare denies payment, I agree to be personally responsible for payment

Medicare Beneficiary Signature __________________________ Date______________

Atlanta Premier OB/GYN Associates, PC

Name_______________________________________ DOB_______________

LMP ____________ normal abnormal Explain_______________________

Medical Problems ____

Past Surgeries____

Allergies ____

Medications ____

Tobacco ____________ Alcohol ____________ Drugs(any)____________

Sexually active __________ protected unprotected

Sexual partner: Male Female Both Number of lifetime partner __________

Ever have any sexually transmitted infections ______________________

How many pregnancies______ How many births______ How many abortions/miscarriages ______

Any problems with pregnancies ________________________________

Last pap ______________ normal abnormal

Last mammogram __________ normal abnormal

Last colonoscopy __________ normal abnormal

Any history of abuse (physical, sexually) ________________________

Any medical problems run in your family

____

____

Do you have concerns/problems with your current weight ______________

Do you have concerns/problems with sex __________________________

Do you have concerns/problems with BV or odor ____________________

ATLANTA PREMIER OB/GYN ASSOCIATES, PC

1. Do you have regular monthly periods? ______________________________
2. How many days do your periods last? ______________________________
3. How many pads/tampons do you use in a day? ______________________________
4. Do over the counter medications improve your pain with your periods? ______________
5. Do you urinate (pee) on yourself when you cough, laugh or sneeze? ______________
6. Are you interested in having more children? ______________________________
7. Do you have regular or constant pelvic pain? ______________________________
8. Do you feel like you always have yeast infections? ______________________________
9. Do you have pelvic pain after intercourse? ______________________________
10. Do you have vaginal pain after intercourse? ______________________________
11. Do you have spotting/bleeding after intercourse? ______________________________
12. Do you feel like you always have bacterial vaginitis? ______________________________
13. Do you have persistent vaginal odor? ______________________________

Atlanta Premier OB/GYN Associates, PC

CONSENT FOR STD TESTING

Please initial your choice and sign below

_____ **I authorize** the doctor's office to test me for Sexually Transmitted Disease (STD).

In signing this consent form, I acknowledge that insurance may cover the cost. However the STD test may be subjected to the patient's deductible which is your responsibility.

_____ **I do not authorize** blood collection for STD's testing.

____
Patient Signature

____
Signature of witness

Date ____________

I have consulted with the above mentioned person about testing him or her for STD, about the availability and necessity of post-testing counseling, and the test results will be handled confidentially as prescribed by law.

____
Date

____
Signature of Physician

ATLANTA PREMIER OB/GYN ASSOCIATES, PC

CONSENT FOR HIV TESTING

Please initial your choice and sign below

____ I authorize the doctor's office to test me for HIV, the virus that causes Acquired Immunodeficiency Syndrome (AIDS) and related syndromes.

In signing this consent form, I acknowledge that I have been offered and/or provided with information about this test, about the HIV virus and about AIDS. I have been given the opportunity to ask questions regarding this information and my questions have been answered.

I have been informed that both my request the HIV test and the test results are considered confidential and will be released only to me except as required or permitted by law.

If the test results are positive, I will be provided information about the consequences for my own health care so that I might take precautions to prevent transmission of the virus to others.

I understand that Georgia law requires the reporting of confirmed positive test results to the Public Health Department.

I understand that, unless otherwise limited by state and federal regulations, and except to the extent that actions has been taken which was based on my consent, I may withdraw this consent at any time.

____ I do not authorize blood collection for HIV antibody testing.

____
Patient Signature

____
Signature of Witness

Date ________________________

I have consulted with the above mentioned person about testing him or her for HIV, about the availability and necessity of post-testing counseling, and the test results will be handled confidentially as prescribed by law.

____
Date

____
Signature of Physician

Atlanta Premier OB/GYN Associates, PC

In an effort to provide the best experience during your office visit today and help us keep current on your health, please take a few minutes to complete the following questions. Thanks you!

Name____**Date**________________________

CONTRACEPTION

1. What is your current form of birth control?

2. How long have you been using your current form of birth control? *(please check one)*
   ___Two years or less ___3 to 5 years ___6 to 10 years ___Over 10 years

3. When are you planning to have another child? *(please check one)*
   ___Within the next year ___Within the next 5 years
   ___Within the next 10 years ___My family is complete

4. Would you like information on a non-surgical, hormone-free permanent birth control procedure performed in the comfort of our office?

MENSTRUAL PERIODS

1. How long does your average monthly period last? __________Days

2. Do you ever feel as though your periods impact the quality of your life? ___Yes ___No

3. Do you experience irregular, inconsistent, or heavy bleeding? ___Yes ___No

4. Are you periods painful? ___Yes ___No

5. Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods? ___Yes ___No

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1. Do you have any allergies Yes No

___

___

2. Would you like to know what you're allergic to? Yes No

___

3. Would you like for us to find out? Yes No

ATLANTA PREMIER OB/GYN ASSOCIATES, PC
764 Memorial Dr SE Suite 101, Atlanta, GA 30316
PHONE (678) 705-4900
FAX (678) 705-5441

AUTHORIZATION FOR RELEASE OF INFORMATION

The patient listed below has authorized the release of medical Information from

____

____

Please forward the following medical records for the patient.

_____ Progress Notes

_____Labs/Cytology/Pathology/Radiology

_____ Correspondence

_____ H & P

Patients Name ____

D.O.B. ____________________________

Patient Signature ____

*******STAT REQUEST PATIENT IN THE OFFICE*********

801 Broadway Ave NW, Suite 203 , Grand Rapids, MI 49504
Phone: (855) 776-9436 · Fax: (616) 710-4667
info@nxgenmdx.com · www.nxgenmdx.com
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NxGen MDx

NxGen Hereditary Cancer Panel Family History Questionnaire

Do you have a family history of cancer? Answer these questions.

Name: ______________________

Date of Birth: ______________________

Today's Date: ______________________

Have you or any of your relatives had BREAST CANCER?

NO ☐ YES ☐ →

N ☐ Y ☐ **Do you have two or more relatives with any of these cancers (including yourself)?**
☐ Breast ☐ Pancreatic ☐ Prostate

N ☐ Y ☐ **Do you have grandparents who are Ashkenazi Jewish?**

Have you or any of your relatives been diagnosed with

N ☐ Y ☐ Breast cancer at age 45 or younger?

N ☐ Y ☐ Male breast cancer?

N ☐ Y ☐ Triple negative breast cancer at the age 60 or younger?

N ☐ Y ☐ Two different breast cancers, with the first diagnosed at age 50 or younger?

*If you marked **yes** to any of these options, fill out the other side of this page.*

Have you or any of your relatives had COLON, UTERINE, STOMACH, OR OTHER LYNCH SYNDROME-RELATED CANCERS?

NO ☐ YES ☐ →

N ☐ Y ☐ **Do you have two or more relatives with any of these cancers (including yourself)?**
☐ Colorectal Cancer ☐ Small Bowel Cancer
☐ Ureter Cancer ☐ Uterine Cancer
☐ Biliary Tract Cancer ☐ Brain Tumors
☐ Stomach Cancer ☐ Kidney Cancer
☐ Pancreatic Cancer

N ☐ Y ☐ **Have you or any of your relatives (parents, children, siblings) been diagnosed with colorectal or uterine cancer at age 49 or younger?**

N ☐ Y ☐ **Have you or any of your relatives been diagnosed with two different types of Lynch syndrome-related cancer (in the same person)?**

*If you marked **yes** to any of these options, fill out the other side of this page.*

Have you or any of your relatives had OVARIAN, FALLOPIAN TUBE, OR PERITONEAL CANCER?

NO ☐ YES ☐ →

*If you marked **yes** to any of these options, fill out the other side of this page.*

If you answered NO to all of the questions, you do not need to fill out the other side of this page.

OFFICE USE ONLY *Reviewed by:* ______________

Are outlined questions checked on the front side?
Y ☐ → Turn to other side and count the cancers.
N ☐

Are shaded questions checked on the front or back side?
Y ☐ → Patient likely meets NCCN criteria. → Patient accepted testing? Y ☐ N ☐ Date drawn: ______________
N ☐

NxGen MDx

Hereditary Cancer Family History Questionnaire (continued)

Name: ____________________

Date of Birth: ____________________

Complete this side only if you have relatives with the following cancers:

☐ Breast ☐ Ovarian ☐ Lynch Syndrome-Related
☐ Pancreatic ☐ Prostate
☐ Peritoneal ☐ Fallopian

Colorectal, Small Bowel, Ureter, Uterine, Biliary Tract, Brain Tumors, Stomach, Kidney

You and your immediate family

You
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

Mother
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

Father
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

Siblings ☐ Brother ☐ Sister
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

Siblings ☐ Brother ☐ Sister
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

Relatives on your mother's side

Maternal Aunt/Uncle ☐ Aunt ☐ Uncle
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

Maternal Aunt/Uncle ☐ Aunt ☐ Uncle
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

Maternal Grandmother
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

Maternal Grandfather
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

Maternal Other ____________
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

Relatives on your father's side

Paternal Aunt/Uncle ☐ Aunt ☐ Uncle
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

Paternal Aunt/Uncle ☐ Aunt ☐ Uncle
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

Paternal Grandmother
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

Paternal Grandfather
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

Paternal Other ____________
Cancer site or polyp type (Add # for colon/rectal adenomas) ____________________ Age of diagnosis: ________

OFFICE USE ONLY

If outlined questions are checked on the front, count the affected relatives on the same side of the family. Relatives in the top category (YOU, YOUR SIBLING, etc.) count on both sides of the family

N☐ Y☐ 3 people on the same side of the family with **breast, pancreatic, or prostate cancer?**

N☐ Y☐ 2 people on the same side of the family with **breast, pancreatic, or prostate cancer,** with one person diagnosed with breast cancer at the age 50 or younger?

N☐ Y☐ 3 people on the same side of the family with **Lynch-related or pancreatic cancer?**

N☐ Y☐ 2 people on the same side of the family with **Lynch-related or pancreatic cancer,** with one person diagnosed at the age 49 or younger?

MISSED APPOINTMENT AND CANCELLATION POLICY

If you are unable to keep a scheduled appointment, please give 24 hours advance notice to ensure that you will not be charged for the appointment.

If less than 24-hour notice is given, you will be charged a $50.00 CANCELLATION FEE.

Patient Name______________________________

Patient Signature___________________________

Date______________________________________