

Georgia Prenatal
Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.
Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com



WELCOME TO GEORGIA PRENATAL

We are thrilled that you have chosen to put your gynecological care in our hands!
We happily welcome you to our Georgia Prenatal family & care.

In order to best serve you, we need your help!
If you would please take the time to provide us with the required information &
consents outlined in this packet.

Please read below as we have provided our practice guidelines & rules:

Initials_____

GEORGIA PRENATAL GUIDELINES & RULES

No Call, Now Shows \$25.00
If you fail to call within 24 hours of your appointment this fee will be applied to your account. This excludes Medicaid patients.

15 Minute Rule \$00.00
Please note that if you arrive more than 15 minutes late to your scheduled appointment, you risk being rescheduled or waiting at minimum the same amount of time you were late.

Children Not Allowed Without Supervision \$00.00
For safety, children are not permitted to remain alone in the waiting room or consultation room without a responsible adult.

Medical Records Request \$00.00
You may request copies of your medical results at no additional cost. We do not send results by email, nor do we deliver them to third parties without prior authorization. Copies must be picked up in person at our office.

Georgia Prenatal
Obstetrics-Gynecology

Patient PRN #: _____

950 Indian Trail Lilburn Rd.
Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com



WELCOME TO GEORGIA PRENATAL
PATIENT INFORMATION

Last Name _____

First Name _____

Date of Birth | Month _____ Day _____ Year _____ Age _____

Social Security Number (SS#) _____ Phone Number _____

Email _____

Address | Street Number _____ Street Name _____ Apt. # _____

City _____ State _____ Zip Code _____

Marital Status (Please circle one of the options below):

Single Married Divorced Life Partner Widowed

Occupation _____ Declines to Answer _____

Preferred Language: English Spanish Portuguese Other: _____

Ethnicity _____ Declines to Answer _____

Preferred Method of Communication (Please circle one of the options below):

Email SMS Voice Either, No Preference

INSURANCE INFORMATION

Do you have Health Insurance (Please circle one of the options): Yes No

If you have Health Insurance, fill in the information below:

Name of Primary Medical Insurance: _____ Policy Number: _____

Name of Secondary Health Insurance: _____ Policy Number: _____

EMERGENCY CONTACT

First & Last Name _____ Mobile Phone Number _____

Address _____ Relationship to Patient _____

Georgia Prenatal
Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.
Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com



FINANCIAL POLICY

Our goal in Georgia Prenatal is to keep your insurance and other financial arrangements as simple and clear as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

- ❖ I authorize the release of medical information to my Primary or Secondary Insurance Company as necessary to process insurance claims, insurance applications, prior authorizations, and prescriptions.
- ❖ I also authorize payment of medical benefits to the physicians.
- ❖ I am ultimately responsible for payment of charges for services I receive in your office not covered by my insurance.
- ❖ It is my responsibility to provide the office with my current address, telephone number and insurance information.
- ❖ It is my responsibility to contact my insurance carrier to confirm that the providers participate with my plan.
- ❖ If my insurance is not Active at the time of service, I will be responsible for payment in full.
- ❖ If I do not provide correct insurance information I will be responsible for payment in full.
- ❖ Co-payment, co-insurance and / or deductible not satisfied is due at the time of service.
- ❖ Lab charges not covered by your medical insurance will be billed to you.
- ❖ Any unpaid charges after delivery will be transferred to an outside collection agency.

Please be advised all patients, with insurance and self-pay (no insurance), must disclose when the patient under our care currently has private insurance, adds private/commercial insurance or medicaid. Georgia Prenatal is not responsible for any charges accrued, nonpayment, or retro pay due to not disclosing information.

I _____ understand and comply with Georgia Prenatal Financial Policy.

Signature _____ Date _____ / _____ / _____

Georgia Prenatal
Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.
Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com



PREFERRED PHARMACY CONSENT

This consent form authorizes Georgia Prenatal to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form you agree that Georgia Prenatal can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payers (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Georgia Prenatal to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Preferred Pharmacy Name _____

Pharmacy Phone Number _____

Address _____

Patient Name _____ Date ____ / ____ / ____

Signature _____ Date ____ / ____ / ____

Witness _____ Date ____ / ____ / ____

Georgia Prenatal
Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.
Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com



MEDICAL TREATMENT & PRIVACY POLICY CONSENT

MEDICAL TREATMENT

Initials _____

By initialing and signing below, I authorize the providers, midwives, and nurse practitioners to treat me at the Georgia Prenatal clinic. I understand that the providers will treat me in accordance with the standards of care established by the American College of Obstetrics and Gynecology. I understand that this treatment may include laboratory tests, ultrasound, and other diagnostic procedures in order to provide me with the best care possible. All information obtained from myself by all Georgia Prenatal providers will be confidential and will remain confidential unless I sign a release of this information to another party. No one will be able to access the information in my Georgia Prenatal records without my prior written permission/consent.

PRIVACY POLICY NOTIFICATION

Initials _____

It is my understanding that Georgia Prenatal has a patient privacy notice and policy, which is available for me at any time. They have made me aware of my rights as a patient and made me a copy of their policies.

(Please circle one of the options):

I choose to receive a copy

I choose not to receive a copy

Patient Name _____ Date _____ / _____ / _____

Signature _____ Date _____ / _____ / _____

Witness _____ Date _____ / _____ / _____

Georgia Prenatal
Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.
Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com



APPOINTMENT REMINDERS & GENERAL COMMUNICATION CONSENT

EMAIL

Initials _____

By initialing & signing below, I am authorizing Georgia Prenatal to send me appointment reminders and practice updates via the email provided in the patient information portion of my registration.

TEXT MESSAGE

Initials _____

By initialing & signing below, I am authorizing Georgia Prenatal to send me appointment reminders and practice updates via the text provided in the patient information portion of my registration. I understand that this service is offered for free of charge. However, standard text messaging rates from my mobile carrier may apply. Please activate text message reminders for my patient mobile phone number.

VOICE MESSAGE

Initials _____

By initialing and signing below, I authorize Georgia Prenatal to call me and leave voice messages, at the phone number I provided in the patient information record, regarding my upcoming appointments and any other general updates related to my care.

Patient Name _____ Date _____ / _____ / _____

Signature _____ Date _____ / _____ / _____

Witness _____ Date _____ / _____ / _____

Georgia Prenatal
Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.
Lilburn, GA 30047
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com



GYNECOLOGIC HISTORY

Allergy to any medication (Please circle one of the options): Yes No

Medication name _____

Are you currently taking any medication: Yes No

Medication name _____

Reason for your visit _____

First day of your last menstrual period | Month _____ day _____ Year _____

How old were you when you first got your period _____

How long does your period last _____

How often does your period come? 28 to 30 days _____ Fewer days _____ More days _____

Do you have pain or cramps when you get your period: Yes No | Light Moderate Severe

Do you have spotting or bleeding between your periods: Yes No | somewhat Much

Date of your last pap smear | Month _____ day _____ Year _____

Have you had a mammogram before: Yes No

Date of your last mammogram | Month _____ day _____ Year _____

Are you sexually active: Yes No

Do you have pain or bleeding during or after sexual intercourse: Yes No

Have you had unprotected sex since your last period: Yes No

What Contraceptive Method are you using | Condoms _____ Intrauterine Device (IUD) _____ Pills _____

Injectons (Depo Provera) _____ Vaginal Ring (Nuvaring) _____ Patches _____ Family Rhythm Method _____

Withdrawal Method _____ Tube Ligation _____ Vasectomy _____ Abstinence _____

Have you been pregnant before: Yes No | How many pregnancies have you had: _____

Have you had a miscarriage: Yes No | How many miscarriages have you had: _____

Have you had an induced abortion: Yes No | How many induced abortions have you had: _____

Have you had an ectopic pregnancy: Yes No | How many ectopic pregnancies have you had _____

Have you had vaginal deliveries: Yes No | How many vaginal deliveries _____

Have you had cesarean sections: Yes No | How many cesareans _____

Any problem urinating (leakage of urine when you cough or sneeze, etc.): Yes No _____

Check if you have had any of the following medical problems in the past or currently:

_____ Abnormal pap smear

_____ Surgeries on female organs

_____ Sexually Transmitted Diseases

_____ Problems related to the device

_____ Breast cancer or some other type

_____ Diabetes

_____ Vaginal Infections

_____ Thyroid Diseases

_____ Ovarian Cysts

_____ Hypertension

_____ Genital Warts

_____ Migraine

Do you smoke: Yes No | How often _____

Do you consume alcohol: Yes No | How often _____

Have you or a member of your family been diagnosed with any of the following diseases:

_____ Diabetes

_____ Migraine

_____ Asthma

_____ Hypertension

_____ Thyroid disease

_____ Depression

_____ Cancer (type of cancer _____)

_____ Epilepsy

_____ Tuberculosis

_____ Hepatitis

_____ Fibroids

_____ Infertility

_____ HIV