

McDaniel & Durrett, PC

This form must be filled out completely in order for us to file your insurance

Date: _____ Referred by: _____ Chart: _____

Status: S M D W DOB: _____ Age: _____ SS#: _____

Name: _____ Pref. Name: _____
Last First M.

Address: _____

Hm.#: _____ Wrk#: _____ City State Zip
Cell#: _____

E-mail: _____ Religion: _____

Patient Employer: _____ Occupation: _____

Spouse/Sig.Other: _____ DOB: _____

Spouse/Sig.Other SS#: _____ Wrk.#: _____

Emergency Contact: _____ Emergency Contact: _____

Relationship: _____ Relationship: _____

Phone #: _____ Phone #: _____

Primary Insurance: _____ Cust.Service #: _____

Policy Holder Name: _____ DOB: _____

Member/Subscriber ID#: _____ Group#: _____

Secondary Insurance: _____ Cust.Service#: _____

Policy Holder Name: _____ DOB: _____

Member/Subscriber ID#: _____ Group#: _____

I understand that it is my responsibility to provide a valid insurance card at the time of my exam. Should my insurance deny coverage on any service(s) rendered, I realize I am responsible for payment. I understand that if I do not have insurance, I am responsible for payment at the time of service. I understand that if I am seventeen years of age or younger, I must be accompanied by a parent or legal guardian.

Patient Signature

Parent or legal Guardian Signature

MCDANIEL & DURRETT, P.C
GYNECOLOGY AND UROGYNECOLOGY

This form is intended to help us review your entire medical history as well as your present problem, if any exist. Please fill out completely:

Name: _____ Date: _____

Yearly Exam Appointment today? YES _____ NO _____ If not, Reason for visit today: _____

Name of Primary Physician: _____ Phone Number: _____

Did she/he refer you to us? YES _____ NO _____ If not, name and phone number of referring physician? _____

GYNECOLOGICAL HISTORY:

Date of Last Pap Smear: _____ Last Pap Smear Results: Normal _____ Abnormal _____

If abnormal, What type of treatment was done? _____

Have you ever had an abnormal pap? YES _____ NO _____ If yes, date and type of treatment done: _____

Date of Last Mammogram: _____ Last Mammogram Results: Normal _____ Abnormal _____

Date of Last Bone Density: _____ Last Bone Density Results: Normal _____ Abnormal _____

Date of Last Colonoscopy: _____ Last Colonoscopy Results: Normal _____ Abnormal _____

Have you ever been diagnosed with an STD? Y / N If yes, please check and specify date of diagnosis:

Herpes I / II / Both _____ Chlamydia _____ Gonorrhea _____ HPV _____

Condyloma/ Warts _____ Syphilis _____ HIV _____

Other: _____

ALLERGY HISTORY:

Please list any allergies to medicines and the side effects: _____

Please list any allergies to any topical/environmental and the side effects: _____

PERSONAL AND SOCIAL HISTORY:

Do you smoke: YES _____ NO _____ If yes, how much? _____ Ever Smoked? YES _____ NO _____

Do you drink alcohol: YES _____ NO _____ SOCIAL _____ If yes, drinks per week? _____

Do you use illicit drugs: YES _____ NO _____ If yes, how long and name of drugs used: _____

Do you or have you ever been addicted to drugs or alcohol? YES _____ NO _____ If yes, what kind? _____

Have you been in treatment? YES _____ NO _____ If yes, type of treatment and date? _____

What is your sexual preference? FEMALE _____ MALE _____ BOTH _____

Are you sexually active? YES _____ NO _____ Date of last intercourse _____

Age of first intercourse _____ Number of partners in the last year _____ Number of partners in lifetime _____

Have you ever been a victim of sexual trauma or rape? YES _____ NO _____ Have you been in treatment? Y / N

If yes, type of treatment and date _____

Education: _____ High School (degree Y / N) _____ College (degree Y / N) _____ Graduate School

Living: _____ Alone _____ Family _____ Retirement Home _____ Nursing Home _____ Roommate

MENSTRUAL HISTORY:

Date of last normal menstrual period _____ Age at first period _____

When not on birth control pills, are your periods? ____ Regular ____ Irregular

The interval between the first day of one period to the first day of next period ranges from _____ to _____ days.

Menstrual flow usually lasts for a total of _____ days.

Menstrual flow is usually: ____ Scant ____ Moderate ____ Heavy ____ Excessive with Clots

Are your periods painful: Y / N If yes, how severe? ____ Mild ____ Moderate ____ Incapacitating

Have you ever had pain during or after intercourse? Y / N If yes, when? _____

Do you ever have spotting or bleeding between periods or following intercourse? Y / N

Have you ever been diagnosed with any of the following:

- | | | |
|---------------------------------|------------------------------|----------------------------------|
| _____ Fibroids | _____ Uterine anomalies | _____ Polyps of uterus or cervix |
| _____ Abnormal Uterine Bleeding | _____ Endometriosis | _____ PCOS |
| _____ Ovarian Cyst | _____ Ovarian/Uterine Cancer | |

UROGYNECOLOGICAL HISTORY:

Do you currently have any vaginal discharge, irritation, and/or itching? Y / N If yes, for how long? _____

Do you frequently have loss of urine with sneezing or coughing? Y / N If yes, times per day? _____

Do you frequently have a sudden urgent need to urinate? Y / N If yes, for how long? _____

Do you have frequent night urination or bed wetting? Y / N If yes, times per week? _____

Do you have painful urination or difficulty in starting urination? Y / N If yes, for how long? _____

Do you ever have a bulging sensation from your vagina? Y / N If yes, for how long? _____

OBSTETRIC HISTORY:

How many babies full term (> 5.5 lbs)? _____ How many babies premature? _____

How many miscarriages? _____ How many abortions? _____ How many ectopic pregnancies? _____

How many living children do you currently have? _____ Age of oldest child _____ Age of youngest child _____

How many of your children were born by cesarean section (C-Section)? _____

How many of your children had birth defects? _____ List defects: _____

Any serious complications with any of your pregnancies? Y / N Explain: _____

SURGICAL HISTORY:

Please check if you ever had any of the following surgeries:

| | DATE | | DATE |
|--|-------|---|-------|
| <input type="checkbox"/> Appendix | _____ | <input type="checkbox"/> Hemorrhoids | _____ |
| <input type="checkbox"/> Gall Bladder | _____ | <input type="checkbox"/> Kidney | _____ |
| <input type="checkbox"/> Tonsils | _____ | <input type="checkbox"/> Thyroid | _____ |
| <input type="checkbox"/> Breast augmentation / reduction | _____ | <input type="checkbox"/> Breast lumpectomy / mastectomy | _____ |
| <input type="checkbox"/> Breast | _____ | <input type="checkbox"/> C-Sections | _____ |
| <input type="checkbox"/> Heart | _____ | <input type="checkbox"/> Ovaries removed | _____ |
| <input type="checkbox"/> Tubes / Tubal ligation | _____ | <input type="checkbox"/> Hysterectomy | _____ |
| <input type="checkbox"/> Vaginal | _____ | <input type="checkbox"/> Bladder | _____ |
| <input type="checkbox"/> Hernia | _____ | <input type="checkbox"/> D & C | _____ |
| <input type="checkbox"/> Ovarian cyst | _____ | <input type="checkbox"/> Fibroids | _____ |
| <input type="checkbox"/> Colon | _____ | <input type="checkbox"/> Varicose Veins | _____ |

Other: _____

MEDICAL HISTORY:

Please check any of the following health problems you have had or were diagnosed with:

| | DATE OF DIAGNOSIS | | DATE OF DIAGNOSIS | | DATE OF DIAGNOSIS |
|---|----------------------|--|----------------------|---|----------------------|
| <input type="checkbox"/> Anemia | _____ | <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Hypertension | _____ |
| <input type="checkbox"/> Ulcer / Reflux | _____ | <input type="checkbox"/> Cancer | _____ | <input type="checkbox"/> Abnormal cholesterol | _____ |
| <input type="checkbox"/> Epilepsy | _____ | <input type="checkbox"/> Asthma / Hayfever | _____ | <input type="checkbox"/> Migraine | _____ |
| <input type="checkbox"/> Ulcerative Colitis | _____ | <input type="checkbox"/> Crohn's Disease | _____ | <input type="checkbox"/> Anxiety | _____ |
| <input type="checkbox"/> Blood clots/ Phlebitis | _____ | <input type="checkbox"/> IBS | _____ | <input type="checkbox"/> Nervous breakdown | _____ |
| <input type="checkbox"/> Varicose Veins | _____ | <input type="checkbox"/> Hernia | _____ | <input type="checkbox"/> Skin disease | _____ |
| <input type="checkbox"/> HeartMurmur | _____ | <input type="checkbox"/> Arthritis | _____ | <input type="checkbox"/> Osteopenia | _____ |
| <input type="checkbox"/> Lupus | _____ | <input type="checkbox"/> Fibromyalgia | _____ | <input type="checkbox"/> Liver disease | _____ |
| <input type="checkbox"/> Obesity / Anorexia | _____ | <input type="checkbox"/> Depression | _____ | <input type="checkbox"/> Gallbladder | _____ |
| <input type="checkbox"/> Other: | _____ | | | | |

Have your current medical problems been treated by a physician? Y / N If not, explain: _____

Have you ever had a blood transfusion? Y / N If yes, date and place where performed _____

Have you ever been hospitalized (besides Pregnancy) for any other non-surgical illness? Y / N

If yes, diagnosis and year:

Please check any of the following infectious diseases you have been diagnosed with:

| | DATE OF DIAGNOSIS | | DATE OF DIAGNOSIS |
|--|-------------------|--|-------------------|
| <input type="checkbox"/> Measles | _____ | <input type="checkbox"/> German Measles | _____ |
| <input type="checkbox"/> Mumps | _____ | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Rheumatic Fever | _____ | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Tuberculosis | _____ | <input type="checkbox"/> Hepatitis A / B / C | _____ |
| <input type="checkbox"/> Pneumonia | _____ | <input type="checkbox"/> Encephalitis | _____ |
| <input type="checkbox"/> Meningitis | _____ | <input type="checkbox"/> Infection on tubes | _____ |
| <input type="checkbox"/> Bladder/ Kidney Infection | _____ | <input type="checkbox"/> Staph infection | _____ |
| <input type="checkbox"/> Other: | _____ | | |

Please check any of the following symptoms you currently have or have had during the past six months:

| | ONSET OF SYMPTOMS | | ONSET OF SYMPTOMS |
|---|-------------------|---|-------------------|
| <input type="checkbox"/> Eye, Ear, Nose, Throat problem | _____ | <input type="checkbox"/> Loss of consciousness / fainting | _____ |
| <input type="checkbox"/> Seizures | _____ | <input type="checkbox"/> Chronic Cough | _____ |
| <input type="checkbox"/> Chest pain | _____ | <input type="checkbox"/> Shortness of Breath | _____ |
| <input type="checkbox"/> Rapid or irregular heartbeat | _____ | <input type="checkbox"/> Lumps in breast | _____ |
| <input type="checkbox"/> Breast discharge or change in size | _____ | <input type="checkbox"/> Hot flashes | _____ |
| <input type="checkbox"/> Loss or gain weight (>10lbs/6 mth) | _____ | <input type="checkbox"/> Nausea and/or Vomiting | _____ |
| <input type="checkbox"/> Diarrhea/ Constipation | _____ | <input type="checkbox"/> Blood or mucous in stool | _____ |
| <input type="checkbox"/> Black/ Tarry stool | _____ | <input type="checkbox"/> Back pain | _____ |
| <input type="checkbox"/> Joint paint | _____ | <input type="checkbox"/> Leg cramps | _____ |
| <input type="checkbox"/> Persistent anxiety | _____ | <input type="checkbox"/> Persistent depression | _____ |
| <input type="checkbox"/> Other: | _____ | | |

FAMILY HISTORY:

Please check if a member of your family has or ever had any of the following medical problems:

| | MEMBER OF FAMILY | AGE OF ONSET | | MEMBER OF FAMILY | AGE OF ONSET |
|---|------------------|--------------|--|------------------|--------------|
| <input type="checkbox"/> Diabetes | _____ | _____ | <input type="checkbox"/> Heart Disease | _____ | _____ |
| <input type="checkbox"/> Stroke | _____ | _____ | <input type="checkbox"/> High Cholesterol | _____ | _____ |
| <input type="checkbox"/> Thyroid Disease | _____ | _____ | <input type="checkbox"/> Uterine Cancer | _____ | _____ |
| <input type="checkbox"/> Ovarian Cancer | _____ | _____ | <input type="checkbox"/> Breast Cancer | _____ | _____ |
| <input type="checkbox"/> Osteoporosis | _____ | _____ | <input type="checkbox"/> Colon Cancer | _____ | _____ |
| <input type="checkbox"/> High Blood Pressure | _____ | _____ | <input type="checkbox"/> Low Blood Pressure | _____ | _____ |
| <input type="checkbox"/> Bleeding Disorder | _____ | _____ | <input type="checkbox"/> Clotting Disorder | _____ | _____ |
| <input type="checkbox"/> Anemia | _____ | _____ | <input type="checkbox"/> Ulcerative Colitis | _____ | _____ |
| <input type="checkbox"/> Crohn's Disease | _____ | _____ | <input type="checkbox"/> Liver Disease | _____ | _____ |
| <input type="checkbox"/> Alzheimer's Disease | _____ | _____ | <input type="checkbox"/> Parkinson's Disease | _____ | _____ |
| <input type="checkbox"/> Pancreatic Cancer | _____ | _____ | <input type="checkbox"/> Skin Cancer | _____ | _____ |
| <input type="checkbox"/> Hertzprung's Disease | _____ | _____ | <input type="checkbox"/> Genetic Defects | _____ | _____ |
| <input type="checkbox"/> Other: _____ | _____ | | | | |

KNOWING YOUR INSURANCE & YOUR PAYMENT RESPONSIBILITIES

As the patient, it is your responsibility to provide us with accurate and up to date insurance information. As a courtesy, we will gladly file claims to your insurance company on your behalf, based upon the information you have provided. If for some reason your insurance company does not pay for all of your visit, a portion of your visit, and/or does not pay in a timely fashion; you, as the patient, are ultimately responsible for the services rendered.

CANCELLATION POLICY

A CERTAIN AMOUNT OF TIME IS HELD SPECIFICALLY FOR YOU WHEN YOU SCHEDULE AN APPOINTMENT. AS A COURTESY TO OUR PROVIDERS & OTHER PATIENTS ALSO IN NEED OF MEDICAL ATTENTION; WE REQUIRE A 24 HOUR NOTICE IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT FOR ANY REASON. OTHERWISE, A \$50.00 FEE WILL BE ASSESSED TO YOUR ACCOUNT.

_____ I have read & understand the above guidelines. I understand that I am
(initial) responsible for knowing my insurance company's guidelines & informing
McDaniel & Durrett, P.C. of those guidelines. I understand that if I do not
adhere to the cancellation policy, I will be charged a \$50.00 fee that must be
paid before any future appointments can be scheduled.

PREFERRED METHOD(S) OF CONTACT

Primary Contact Phone Number _____

Secondary Contact Phone Number _____

_____ I give my consent to leave messages with DETAILED information.
_____ I DO NOT give my consent to leave messages with DETAILED information.

I authorize McDaniel & Durrett, P.C. to discuss my Private Healthcare Information with the following person(s): _____.

Patient Signature

Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for the office of McDaniel & Durrett, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Please see the office's Notice of Privacy Practice booklets located in the lobby for a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of McDaniel & Durrett reserves the right to revise its Notice of Privacy Practices at any time. A copy of these Practice revisions will be available in our lobby as an addendum to the original version.

With this consent, the office of McDaniel & Durrett may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of McDaniel & Durrett may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, test results, and patient statements.

I have the right to request that the office of McDaniel & Durrett, P.C. restrict how it uses or discloses my PHI to carry out TPO. These requests must be presented in writing to the Practice Manager. The practice of McDaniel & Durrett, P.C. is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

By signing this form, I am consenting to the office McDaniel & Durrett, P.C. use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent ,or later revoke it, the office of McDaniel & Durrett, P.C. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Patient's Name

Print Name of Patient or Legal Guardian

Date

McDaniel & Durrett, P.C.

105 Collier Road, N.W., Suite 1080

Atlanta, GA 30309

Cervical Cancer Screening

There has been an exciting development in cervical cancer screening, which McDaniel & Durrett, P.C. are pleased to offer our patients. If you are 30 years or older, adding the test for Human Papilloma Virus (HPV) greatly improves the accuracy of cervical cancer screening, allows your provider to better determine your risk of cervical cancer or it's precursors, and provides guidance on how often you should be screened.

Most insurance companies cover the HPV test when used with a Pap test for cervical cancer screening of women 30 years of age & older. However, the elected health benefit plan you or your employer chose, may not cover the test. If the test is not paid for by your insurance company, you will receive a bill from the laboratory. **You may call 1-866-895-1478 to obtain coverage & benefit information for your plan specifically.**

Cervical cancer screening guidelines recommend that every woman 30 years of age and older receive the HPV test along with her Pap test. McDaniel & Durrett, P.C. recommend this as well.

_____ I would like to add the HPV test to my pap smear.

_____ I would not like to add the HPV test to my pap smear.

Patient Signature

Date

