SAVANNAH

ph. 912.303.0891 • x: 912.303.0893 • UROGYNsavannah.com • 5356 Reynolds Street | Suite 301 • Savannah, GA 31405

PATIENT REGISTRATION FORM

Date _____ Patient Name _____ DOB _____ SSN _____
(Last, First, Middle Initial)

Address: _____
(City, Street, State, Zip)

Home Phone Number (____)_____ Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed Occupation _____

Employer Name and Phone Number _____ (____) _____

Emergency Contact Name and Phone Number _____ (____) _____

Referred By _____ Primary Care Physician & Phone Number _____

Primary Insurance Plan Name & Claims Address _____
(Located on back of card)

Insurance Policy Number _____ Group Number _____

Policy Holder/Subscriber _____ Relationship ☐ Self ☐ Child ☐ Spouse ☐ Other

Secondary Insurance Plan Name & Claims Address _____
(Located on back of card)

Insurance Policy Number _____ Group Number _____

Policy Holder/Subscriber _____ Relationship ☐ Self ☐ Child ☐ Spouse ☐ Other

Person Financially Responsible for Services/Relationship to Patient _____

What lab does your insurance prefer?	What hospital does your insurance prefer?	What is your preferred pharmacy/location?	Does this visit require a referral/authorization?
☐ LabCorp ☐ Smith Kline ☐ Candler ☐ Quest ☐ Memorial ☐ LabOne	☐ Memorial Health University Medical Center ☐ St. Joseph's/Candler		☐ Yes ☐ No

Referrals: It is your responsibility to understand your insurance plans and know which services require a referral. If we do not have a referral you may be given the option of rescheduling or assuming financial responsibility for the visit by signing a waiver. Contracted facilities: Your insurance contract may require that you participate with specific physicians, hospitals, and labs. It is your responsibility to understand these requirements and advise our staff of such provisions. Our office cannot be responsible for rejected claims as a result of the use of non-contracted labs and hospitals. Co-Payments: Co-payments are due prior to services rendered. Medicare:DOES NOT COVER ROUTINE SERVICES. Payment is expected at the time of service.

Please sign below indicating:

- *I have read the above and fully understand my insurance responsibilities.*
- *I consent to Urogyn to render medical care deemed necessary by Joseph T. Stubbs III, MD.*
- *I authorize Urogyn and its agents to bill my insurance company for services rendered.*
- *I authorize Urogyn and its agents to release any medical information required by my insurance to determine benefits payable*
- *I authorize that payment be made directly to Urogyn.*

Signature Patient/Guardian _____ *Date* _____

URGYN
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PLEASE FILL THIS FORM OUT IN ITS ENTIRETY

Patient Name:_____ Date: _____

Marital Status:_____ DOB: _____ Age: _____

Occupation: _____ Did someone refer you?_____ If so, who?_____

Have you ever seen Dr. Stubbs before?_____ If yes, when and why? _____

Describe as thoroughly as possible the reason for today's visit. Include all symptoms, how long you have experienced them and indicate whether they are better, worse or remained the same.

_____

_____

Menstrual History (Skip this section if you are menopausal or have had a hysterectomy)

Age at first period: _____ Date of last period: ___/___/___ Date of previous period: ___/___/___

Interval between periods (first day menses to first day of next menses): _____Days

Length of period (number of days bleeding each month):_____ Days

Do you have irregular periods? ☐No ☐Yes

Is the bleeding heavy? ☐No ☐Yes

Usual number of pads/tampons used on heaviest day:_____ Pads or tampons: _____

Cramps: ☐None ☐Mild ☐Moderate ☐Severe

Medicine used for cramps:_____

Menopausal History (If not menopausal, skip to the next section)

Age of Menopause:_____Bleeding since menopause? ☐No ☐Yes

Are you on any hormones? ☐No ☐Yes If yes, when did you start? _____

Have you ever been on hormones? ☐No ☐Yes

If yes, when, for how long, and why did you stop?_____

_____

Gynecologic History

Date of last Pap smear?___/___/___ ☐Normal ☐Abnormal

Have you ever had an abnormal Pap smear? ☐No ☐Yes When? _____

If yes, what was done?_____

Have you had a Hysterectomy? ☐No ☐Yes Why? _____

Date of last mammogram: ___/___/___ ☐Normal ☐Abnormal

Have you ever had an abnormal mammogram? ☐No ☐Yes When? _____

If yes, what was done?_____

Gynecologic History continued

Are you currently sexually active? ☐ No ☐ Yes Have you been sexually active in the past? ☐ No ☐ Yes

Total number of sexual partners in the last year? _____ Total number of sexual partners in lifetime? _____

Do you have pain/discomfort with sex? _____

Have you had, or do you have:	No	Yes	Explain
Fibroids	☐	☐	_____
Endometriosis	☐	☐	_____
Infertility	☐	☐	_____
Any Pelvic Infections	☐	☐	_____
Pelvic Inflammatory Disease (PID)	☐	☐	_____
Gonorrhea	☐	☐	_____
Chlamydia	☐	☐	_____
Syphilis	☐	☐	_____
HPV of Venereal Warts	☐	☐	_____
Herpes	☐	☐	_____
HIV or AIDS	☐	☐	_____
Trichomoniasis	☐	☐	_____
Bacterial Vaginosis	☐	☐	_____
Cancer of the: Breast	☐	☐	_____
Ovary	☐	☐	_____
Uterus	☐	☐	_____
Cervis	☐	☐	_____
Fibrocystic breast changes	☐	☐	_____

Are you currently having:

Problems with Mesh	☐	☐	_____
Frequent urination	☐	☐	_____
Urinary urgency	☐	☐	_____
Incomplete bladder emptying	☐	☐	_____
Pain with urination	☐	☐	_____
Blood in urine	☐	☐	_____
Frequent bladder infections (UTIs)	☐	☐	_____

Do you urinate more than once a night? _____ How many times? _____

Do you leak urine? _____ How long (weeks, months, years)? _____

What causes you to leak urine? _____
(laughing, coughing, sneezing, running, extreme urgency, other)

Do you use anything for protection from leakage of urine? _____
(pads, panty liners, tissue, Depend undergarments, dark clothing)

If yes, what and how many each day? _____

Have you ever had your leakage treated? _____ How? _____

Do you leak stool? _____

Do you have prolapse or dropping of your bladder, uterus or rectum? _____

Which? _____

Have you ever had your prolapse treated? _____ How? _____

Gynecologic History continued

What contraception do you use? (How do you prevent pregnancy) _____

Please list all forms of contraception you have used in the past. _____

_____

Have you had any complications from using any forms of contraception? Which ones and what happened?

_____

Obstetrical History (Please list each pregnancy and the requested information)

Total Pregnancies _____ Term Births _____ Preterm (<5lb, 90z) _____ Living Children _____

Miscarriages _____ Abortions _____ Ectopics (Tubal pregnancy) _____

Date	Wks. Gestation	Vaginal or C-Section	Weight of Baby	Male | Female	Complications

Have you had, or do you have:	No	Yes	Explain
Thyroid problems	☐	☐	_____
Diabetes	☐	☐	_____
Asthma	☐	☐	_____
Blood Clots	☐	☐	When?_____
High Blood Pressure (hypertension)	☐	☐	_____
Heart Problems	☐	☐	Which?_____
High Cholesterol (hyperlipidermia)	☐	☐	_____
Ulcer Disease	☐	☐	_____
Hepatitis	☐	☐	_____
Irritable Bowel Syndrome	☐	☐	_____
Kidney Stones	☐	☐	_____
Seizures	☐	☐	_____
Stroke	☐	☐	_____
Anemia (low blood count)	☐	☐	_____
Blood Clotting Disorder	☐	☐	_____
Previous Blood Transfusion	☐	☐	Why?_____
Sickle Cell Disease	☐	☐	_____
Arthritis	☐	☐	_____
Other medical problems	☐	☐	_____

Do you object to having blood or blood products?_____

Last colonoscopy: _____ Findings: _____

Who is your Primary Care Provider? _____

Surgical/Hospitalization History

Date	Illness or Operation	Hospital/Physician	Complications

Medication Allergies

Medication	Reaction

Current Medication (Please include all over-the-counter and non-prescription drugs)

Drug	Dosage	Frequency

Social History

	No	Yes	How Much/How Often
Do you smoke cigarettes?	☐	☐	_____
Do you drink alcohol?	☐	☐	_____
Do you exercise?	☐	☐	_____
Do you perform self breast exams?	☐	☐	_____
Recreational drug use?	☐	☐	_____

Review of Systems

General	No	Yes	Explain
Recent changes in weight	☐	☐	
Fever or chills	☐	☐	
Frequent night sweats	☐	☐	
Tiredness or fatigue	☐	☐	
Neurological			
Headaches/migraines	☐	☐	_____
Respiratory			
Shortness of breath	☐	☐	_____
Chronic cough	☐	☐	_____
Hematological			
Easy bruising	☐	☐	_____
Prolonged bleeding	☐	☐	_____
Eyes, Ears, Nose, Throat			
Visual problems	☐	☐	_____
Hearing problems	☐	☐	_____
Cardiovascular			
Limited exercise tolerance	☐	☐	_____
Chest pain or discomfort	☐	☐	_____
Palpitations	☐	☐	_____
Gastrointestinal			
Frequent vomiting	☐	☐	_____
Blood in stools	☐	☐	_____
Frequent heartburn/indigestion	☐	☐	_____
Frequent abdominal pain	☐	☐	_____
Diarrhea	☐	☐	_____
Constipation	☐	☐	_____
Skin			
Moles that are changing	☐	☐	_____
New moles	☐	☐	_____
Musculoskeletal			
Joint stiffness	☐	☐	_____
Joint pain	☐	☐	_____
Joint swelling	☐	☐	_____
Psychological			
Anxiety or panic attacks	☐	☐	_____
Depression	☐	☐	_____

IMPORTANT: You will need to address all your medical issues and concerns with your Primary Care Provider.

Family History

Anyone in the family with: Which family member? _____

Heart disease	_____	Diabetes	_____
Sickle cell	_____	Birth defects	_____
Colon cancer	_____	Hypertension	_____
Breast cancer	_____	Psychiatric disorder	_____
Ovarian cancer	_____	Clotting disorder	_____
Other cancers (type)	_____	Tuberculosis	_____

OFFICE USE ONLY

Ba _____

GH _____

Bp _____

PB _____

C _____

TVL _____

Hypermobility: YES NO

Stress Incontinence: YES NO

Supine Standing

Introitus: Gaping

Mildly Gaping

Nongaping

Reflexes: BC: _____

AW: _____

Atrophic: YES NO

RC: YES NO