Southeastern OB/GYN Center
Michael J Jackson, MD

Welcome! Thank you for choosing our practice! We look forward to meeting you and providing you with the best medical care possible. Our office is located at 5311 Paulsen Street on the corner of 70th and Paulsen. Please bring your completed paperwork along with your insurance card, picture ID, and co-payment to your appointment. If you need to reschedule or cancel please give our office a minimum of 24 hours notice so we may accommodate other patients. If you have any questions please call the office at 912-355-1111.

Date: _____

Name: _____
First Middle Last

D.O.B_____ SSN: _____

Address: _____

_____
City State Zip

Home Phone: _____ Cell: _____

Work Phone: _____ Employer: _____

Married _____ Single _____ Divorced _____ Widowed _____

Email: _____

Emergency Contact: _____ Phone: _____

Primary Insurance: _____

ID#: _____ Group #: _____

Secondary Insurance: _____

ID#: _____ Group #: _____

(Please complete the information below if you are NOT the subscriber)

Policy Holder Name: _____ D.O.B. _____

SSN: _____ Employer: _____

Phone: _____ Relationship to Patient: _____

Authorization

I authorize examination and medical treatment to the above patient. _____

I authorize all insurance benefits to be assigned to my physician. _____

I authorize the release of any medical information required for treatment, payment, or other healthcare options. _____

I understand that I am responsible for the bill incurred by the above named patient in the event that the insurance does not pay. _____

(over)

Gynecology Health History

ID No.:_____

Today's Date:_____ / _____ / _____

PATIENT IDENTIFICATION *(Please print)*

Patient's Name:_____

Address:_____

_____

Home Telephone No: ( )_____

Work Telephone No: ( )_____

Reason for Seeing Doctor_____

Date of Birth: ____ / ____ / ____ Age: _____ Religion:_____

Marital Status: ❑ S ❑ M ❑ D ❑ SEP ❑ W Race:_____

Education:_____ years Occupation:_____

Employer:_____

Type of Insurance:_____ Policy #:_____

Referring Physician:_____

Primary Physician:_____

1. CURRENT MEDICATIONS ❑ None

_____

_____

_____

2. MEDICATION ALLERGY / SENSITIVITY

List all medications allergic to: ❑ None

_____

_____

_____

MEDICAL HISTORY *(Check the appropriate box)*

Have you or any members of your family had:	You	Your Family
3. High Cholesterol	❑	❑
4. Heart Disease	❑	❑
5. Rheumatic Fever	❑	
6. High Blood Pressure	❑	❑
7. Asthma	❑	
8. Tuberculosis	❑	
9. Diabetes	❑	❑
10. Thyroid Problems	❑	❑
11. Liver Disease	❑	
12. Stomach, Bowel or Gall Bladder Problems	❑	
13. Kidney or Bladder Problems	❑	
14. AIDS (HIV)	❑	❑
15. Hepatitis (type ___)	❑	❑
16. Anemia or Blood Disorder	❑	❑
17. Blood Transfusion	❑	
18. Allergies	❑	
19. Breast Problems	❑	❑
20. Cancer	❑	❑
21. Infertility	❑	
22. Female or Sexual Problems	❑	
23. Chlamydia	❑	
24. Gonorrhea	❑	
25. Herpes (HSV)	❑	
26. Syphilis	❑	
27. Birth Defects or Inherited Diseases	❑	❑
28. Sexual Abuse or Domestic Violence	❑	❑
29. Other Medical Problems	❑	❑
30. **No Known Medical Problems**	❑	❑

31. HOSPITALIZATIONS

List those operations/serious illnesses that have required hospitalization. If more than six, check this box. ❑ *Do not include pregnancies here.*

Month/Year	Illness or Operation	Complications Yes	No
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑

SUBSTANCE USE *(Check only those you use)*

32. Alcohol ❑
Type _____
Amt/day _____

33. Tobacco ❑
Type _____
Amt/day _____

34. Caffeine ❑
Type _____
Amt/day _____

35. Non-Prescribed Drugs ❑
Type _____
Amt/day _____
Type _____
Amt/day _____

36. Street Drugs ❑
Type _____
Amt/day _____
Type _____
Amt/day _____

37. PREGNANCY HISTORY *(Complete all information)*

# of Pregnancies	# of Premature Births	# of Miscarriages	# of Spontaneous Abortions	# of Induced Abortions	# of Living Children

# of Term Births	Born Month/Year	Baby's Sex	Weight at Birth	Weeks Pregnant (Term= 40Wks)	Hours in Labor	Type of Delivery	Type of Anesthesia	Complications Yes	No
1	/		lbs. oz.					❑	❑
2	/		lbs. oz.					❑	❑
3	/		lbs. oz.					❑	❑
4	/		lbs. oz.					❑	❑
5	/		lbs. oz.					❑	❑

38. MENSTRUAL HISTORY

First Day of Last Menstrual Period ____ / ____ / ____

Menarche (Age at First Period)	Interval (No. of Days Between Periods)	Length of Period
years	days	days

Abnormalities: ❑ Excessive Bleeding ❑ Discharge ❑ Pain ❑ None

39. CONTRACEPTIVE HISTORY

Type		Dates Used
Oral Contraceptive	❑	_____
Type(s) _____	❑	_____
_____	❑	_____
IUD	❑	_____
Diaphragm	❑	_____
Norplant	❑	_____
Sponge	❑	_____
Spermicide	❑	_____
Condoms	❑	_____
Other _____	❑	_____

Sterilization ❑ Male ❑ Female

LIFESTYLE

	Yes	No
40. Did your mother take DES or any other hormones when pregnant with you?	❑	❑
41. Have you ever had a Pap test?	❑	❑
If Yes: Date of your last Pap test? ___ / ___ / ___		
Have you ever had abnormal Pap test results?	❑	❑
42. Are you sexually active?	❑	❑
43. Do you have one partner or	❑	one
many partners	❑	many
44. Is intercourse painful for you?	❑	❑
45. Do you do a monthly self breast exam?	❑	❑
46. Have you ever had a mammogram?	❑	❑
If Yes: Date of your last mammogram? ___ / ___ / ___		
47. Do you exercise on a regular basis?	❑	❑

If Yes: Type of exercise _____

Hours per week exercise _____

Check and detail positive findings below. Use reference numbers.

Signature: _____

Initial Gynecology Profile

Patient's Name: _____

ID No.: _____

INITIAL PHYSICAL EXAM

1. Height _____
2. Weight _____
3. Blood Pressure _____

Pelvic Exam	Normal	Abn.	N.E.
4. Ext. Genitalia			
5. Urethral Meatus			
6. Urethra			
7. Bladder			
8. Vagina			
9. Cervix			
10. Uterus (describe)			
11. Adnexa/Parametria			
12. Rectum (Digital Exam)			
13. Anus and Perineum			
14. Other			

General Physical	Normal	Abn.	N.E.
15. Skin			
16. HEENT			
17. Neck			
18. Chest			
19. Breasts			
20. Heart			
21. Lungs			
22. Abdomen			
23. Musculoskeletal			
24. Extremities			
25. Neurological			

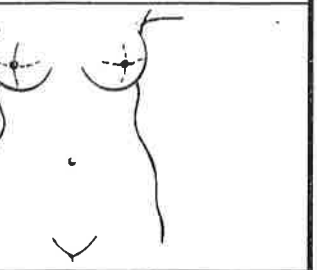
Nutritional Assessment

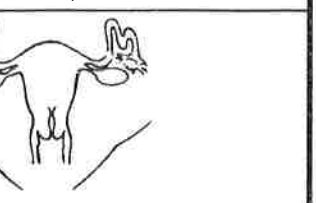
26. Not performed..... ❑
27. Apparently adequate ..... ❑
28. Apparently inadequate..... ❑
29. Excessive caloric intake ..... ❑

Check and detail all positive findings below. Use system numbers.

LABORATORY PROCEDURES

Test	Date	Result
30. Hgb	/	
31. Hct	/	
32. WBC	/	
33. Differential	/	
34. Pregnancy Test	/	
35. Urinalysis	/	
36. HIV	/	
37. Gonorrhea	/	
38. Chlamydia	/	
39. HSV	/	
40. VDRL Serology	/	
41. Hepatitis ___	/	
42. Pap Test	/	
43. Wet Mount	/	
44. Culture	/	
45. Stool Occult Blood	/	
46. Blood Glucose	/	
47. Cholesterol	/	
48. Thyroid Screen	/	
49. Biopsy	/	
50. Mammogram	/	
51.	/	
52.	/	
53.	/	
54.	/	





Diagnosis and Treatment Plans

Next Appointment: ____ /____ /____ Signature: _____

Protected Health Information Disclosure Form

I authorize Southeastern OB-GYN Center, LLC to discuss treatment, appointments, financial obligations, or give other information as necessary with the following family, friends, or personal representatives. I understand that the office will refuse to discuss my information with anyone unless they are listed below. I also understand this consent does not apply to other medical providers.

	Name	Phone Number
1.	_____	_____
2.	_____	_____
3.	_____	_____

_____ _____

Patient Signature Date

HIPAA Notice of Privacy Practices

_____ [Name]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out reatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also escribes your rights to access and control your protected health information. "Protected health information" is information bout you, including demographic information, that may identify you and that relates to your past, present or future physical or ıental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

ses and Disclosures of Protected Health Information
our protected health information may be used and disclosed by your physician, our office staff and others outside of our ffice that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health ıre bills, to support the operation of the physician's practice, and any other use required by law.

reatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and ıy related services. This includes the coordination or management of your health care with a third party. For example, we ould disclose your protected health information, as necessary, to a home health agency that provides care to you. For :ample, your protected health information may be provided to a physician to whom you have been referred to ensure that the ıysician has the necessary information to diagnose or treat you.

ıyment: Your protected health information will be used, as needed, to obtain payment for your health care services. For ample, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the alth plan to obtain approval for the hospital admission.

ealthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business ivities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee view activities, training of medical students, licensing, and conducting or arranging for other business activities. For ample, we may disclose your protected health information to medical school students that see patients at our office. In dition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your ysician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose ur protected health information, as necessary, to contact you to remind you of your appointment.

may use or disclose your protected health information in the following situations without your authorization. These ıations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: use or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral ectors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: ıates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary he Department of Health and Human Services to investigate or determine our compliance with the requirements of Section .500.

er Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity bject unless required by law.

may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's tice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____