ATLANTA NORTH GYNECOLOGY, P.C.

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Religious Preference:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____

Social Security #_____ Place of Birth:_____

Occupation:_____ Employer:_____

Employer Address:_____

Marital Status: ❑ Single ❑Married / Years married_____ ❑Divorced ❑Separated ❑Widowed

Spouse's Name(if applicable)_____

Date of Birth: _____ Work Phone:_____ Cellphone:_____

Occupation:_____ Employer:_____

Nearest Relative (other than Spouse):

Name:_____ Relation:_____

Address:_____ City:_____ State:_____ Zip_____

Home Phone:_____ Work Phone:_____ Cellphone:_____

Person Responsible for Payment:

Name:_____ Phone:_____

Do you have Medical Insurance?_____ Secondary Insurance?_____

How did you hear about us?_____

All patients are requested to pay by check/cash/debit/or credit card at the time of their visits. Please feel free to discuss our charges. If fees are incurred in order to collect any delinquent accounts, these fees will be the responsibility of the patient, in an amount equal to 25% of the balance plus responsible, applicable attorney fees. If in the event of a check return for insufficient funds, a $30.00 fee will be collected for bank reprocessing fees.

(Patient Signature)_____

Authorization To Pay Benefits To Physician or Provider: I hereby authorize payment directly to the undersigned physician or provider of the surgical and/or medical benefits if applicable.

(Patient Signature)_____

Authorization to Release Information: I hereby authorize the undersigned physician or provider to release any information necessary to process medical claims.

(Patient's Signature)_____

ATLANTA NORTH GYNECOLOGY, P.C.

HOWARD A REISMAN, M.D. — *Gynecology and Infertility*
Phone: 770-992-2691 Fax: 770-518-8042

Date: _____

Name: _____ Age: _____ DOB: _____

Reason for Visit/Problems: _____

_____

_____

System Review: Please check any of the following that are significant problems in the last month.							
General:	❑ None	❑ Fever	❑ Fatigue	❑ Weight Loss	❑ Weight Gain		
		❑ Other:					
Eyes/ENT:	❑ None	❑ Headache	❑ Sinusitis	❑ Visual Changes			
		❑ Other:					
Heart/Lungs:	❑ None	❑ Swelling	❑ Chest pain	❑ Palpitation	❑ Shortness of Breath		
		❑ Wheezing	❑ Cough				
Gastrointestinal:	❑ None	❑ Constipation	❑ Diarrhea	❑ Indigestion	❑ Nausea	❑ Bloody Stool	
		❑ Pain	❑ Fecal Loss				
Urinary/Vaginal:	❑ None	❑ Frequency	❑ Urgency	❑ Pain	❑ Blood	❑ Loss of Urine	
		❑ Vaginal Pain	❑ PMS	❑ Abnormal Bleeding		❑ Abnormal Discharge	
Musculoskeletal:	❑ None	❑ Weakness	❑ Muscle Pain	❑ Joint Pain			
		❑ Other:					
Skin/Breast:	❑ None	❑ Rash	❑ Ulcers	❑ Pigmented Lesion		❑ Breast Pain	
		❑ Lump Discharge		❑ Other:			
Neurological:	❑ None	❑ Fainting	❑ Seizures	❑ Numbness	❑ Tremor	❑ Anxiety	❑ Depression
		❑ Crying Spells	❑ Other:				
Endocrine:	❑ None	❑ Excessive Thirst		❑ Hot flushes	❑ Hair Loss	❑ Heat or Cold Intolerance	
Blood/Lymph:	❑ None	❑ Bleeding	❑ Bruises	❑ Enlarged Lymph Nodes			
		❑ Other:					

Last Menstrual Period Date of First Day:	Length:	# of Children Ages of Children

Sexually Active? ❑ Yes ❑ No	# Lifetime Partners	Age Became Sexually Active	Orientation

****** Only complete questions 1–4 if you are an established patient ******

1. Updated Medical History: ***New*** Allergies _____

2. Medical History: (***any recent illnesses or surgeries***)

_____

3. Family History: (***any recent diagnosed disease of close family, i.e. parents, siblings, children***)

_____

4. Social History: (***any changes?***) **Employment** _____ **Occupation** _____

Marital status: M W D S Name of Primary Care Physician _____

Smoking (stop/started) _____ Alcohol social/daily _____ Recreational Drugs _____

May we leave your lab results on your voicemail? _____ **#** _____

Patient Signature _____ **Date** _____

Physician Reviewed _____ **Date** _____

Atlanta North Gynecology, P.C.
Howard A. Reisman, M.D. –Gynecology and Infertility
Phone: 770 992-2691 Fax: 770 518-8042

Name:_____
DOB:_____

Date_____

Surgical History:

Have you or a family (blood related) ever have a reaction to anesthesia?_____
Please List all surgeries and *Date of Surgery*: (Include C-Sections, Tubal Ligations, etc.)

_____

_____

GYN History: (If menopause-state date of last menses)
Last Menstrual Period(**first day**)_____Length of flow_____☐Light ☐Moderate ☐Heavy
Cramps? ☐None ☐mild ☐mod ☐severe What age did you start menstruation?_____
Birth Control Method_____

Medical History: Weight_____ Height_____

Please check if you have ever had the following and approximate year that it was diagnosed:

	YES	Year Diagnosed	Still Present?		YES	Year Diagnosed	Still Present?
Diabetes				High Blood Pressure			
Thyroid Disorder				Cancer Type:_____			
Blood Clots, Phlebitis, Stroke				Urological (Bladder or kidney)/frequent UTI?			
Hepatitis				Gynecological Sexual Transmitted Disease_____			
Anemia				Abnormal Pap HPV?_____			
Gastro-intestinal				Neurological, Migraines, Psychological			
Cardiac/ High Cholesterol				Other:			

Family History:

Please Note which of your **Blood Relatives** have ever been diagnosed with:

	Which relative (also state maternal or paternal)		Relative: maternal/paternal
Diabetes		Blood Clots, Phlebitis, Stroke	
High Blood Pressure		Ovarian Cancer	
Heart Disease		Breast Cancer	
High Cholesterol		Uterine Cancer	
Thyroid Disease		Colon cancer	
Kidney Disease		Other:	

MEDICATION RECORD

Patient: _____ Weight: _____ DOB: _____

Allergies/Reaction:

_____ _____

_____ _____

_____ _____

_____ _____

SCHEDULED MEDICATIONS

Start Date	Medicine	Dosage	Frequency	Stop Date	Comments

PRN MEDICATIONS

Start Date	Medicine	Dosage	Frequency	Stop Date	Comments