

Richard J. Taylor, M.D., Nancy H. Cook, M.D., Kathleen S. Khan, M.D., Dr. Adrienne Zertuche, M.D.,  
 Caitlin Szabo, M.D., Nidhi S. De, M.D., Courtney Franz Adank, MMSc, PA-C

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Age \_\_\_\_\_

REASON FOR VISIT: (If not routine briefly describe main symptoms) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL HISTORY:**

List ALL operations you have had.

List ALL illnesses you have had that required hospitalization.

<u>OPERATION</u>	<u>DATE</u>	<u>ILLNESS</u>	<u>DATE</u>
A. _____	_____	A. _____	_____
B. _____	_____	B. _____	_____
C. _____	_____	C. _____	_____

Have you ever had?

YES	NO	ILLNESS	DATE	YES	NO	ILLNESS	DATE
( )	( )	Anemia	_____	( )	( )	Diverticulitis	_____
( )	( )	Arthritis	_____	( )	( )	Kidney Infection <small>(upper tract)</small>	_____
( )	( )	Bladder Infection	_____	( )	( )	Kidney Stones	_____
( )	( )	Chlamydia	_____	( )	( )	Liver Trouble	_____
( )	( )	Condylomata (genital warts / HPV)	_____	( )	( )	Mental Trouble	_____
( )	( )	Convulsions	_____	( )	( )	Migraines	_____
( )	( )	Diabetes	_____	( )	( )	Pelvic Inflammatory Disease	_____
( )	( )	Heart Murmur	_____	( )	( )	Pneumonia	_____
( )	( )	Heart Trouble	_____	( )	( )	Rheumatic Fever	_____
( )	( )	Herpes - Genital	_____	( )	( )	Serious Injury	_____
( )	( )	High Blood Pressure	_____	( )	( )	Thrombophlebitis	_____
( )	( )	Jaundice / Liver Disease	_____	( )	( )	Thyroid Trouble	_____
( )	( )	Kidney Infection	_____	( )	( )	Tuberculosis	_____
				( )	( )	Ulcers	_____

MEDICATIONS: List all medications that you take REGULARLY or have taken RECENTLY.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

ALLERGIES: Please list any allergies to medications, drugs, chemicals or foods \_\_\_\_\_

HAVE YOU EVER HAD A PROBLEM WITH AN ANESTHETIC? \_\_\_\_\_

**FAMILY HISTORY:**

<u>Relationship</u>	<u>Age</u>	<u>Current Health Problems</u>	<u>Age at Death</u>	<u>Cause of Death</u>
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
Brothers	_____	_____	_____	_____

Did any blood relative (mother, father, sisters, grandparents, aunts, uncles, first cousins, children) ever have any serious medical problems?

**SOCIAL HISTORY:**

Do you smoke cigarettes? \_\_\_\_\_ How many/day? \_\_\_\_\_ How many years? \_\_\_\_\_  
Have you ever smoked cigarettes? \_\_\_\_\_ How long ago did you quit? \_\_\_\_\_  
Do you drink alcohol? \_\_\_\_\_ How many drinks/day? \_\_\_\_\_ Per week? \_\_\_\_\_  
Do you get any regular exercise? \_\_\_\_\_  
Are you married/single/widowed/divorced? \_\_\_\_\_

**GYNECOLOGIC HISTORY:**

**MENSTRUAL HISTORY:**

First day of last period \_\_\_\_\_  
Age first started period \_\_\_\_\_  
Usual # of days from one period to next \_\_\_\_\_  
Usual # of days of flow \_\_\_\_\_  
Are your periods: Light \_\_\_\_\_ Moderate \_\_\_\_\_ Heavy \_\_\_\_\_  
Any excessive bleeding or spotting between cycles? \_\_\_\_\_  
Cramps with periods? \_\_\_\_\_  
Depression, anxiety, emotional upset before periods? \_\_\_\_\_  
Has there been a recent change in you periods? \_\_\_\_\_

**PAP SMEARS:**

Last pelvic exam \_\_\_\_\_ Last pap smear \_\_\_\_\_  
Have you EVER had an abnormal pap Yes \_\_\_\_\_ No \_\_\_\_\_  
If so, what treatment did you receive? \_\_\_\_\_  
Did your mother take hormones while pregnant with you? \_\_\_\_\_

**VAGINITIS:** Have you ever had:

Yeast \_\_\_\_\_ Trichomonas \_\_\_\_\_ Non Specific / Hemophilus Vaginitis / Gardnerella \_\_\_\_\_  
Are you having any problems with discharge now? \_\_\_\_\_

**SEXUAL HISTORY:**

Any problems with pain? \_\_\_\_\_ Orgasm \_\_\_\_\_ Other \_\_\_\_\_

IF YOU WOULD LIKE TO DISCUSS SEXUAL ISSUES WITH THE DOCTOR, PLEASE DO NOT HESITATE

**CONTRACEPTIVE HISTORY:**

List PRESENT and PREVIOUS HISTORY of birth control you have used.

	<u>TYPE OF METHOD</u>	<u>DURATION OF USE</u>	<u>COMPLICATIONS</u>
1. (PRESENT)	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

OBSTETRIC HISTORY: List ALL pregnancies, dates, and outcomes.

	<u>DATE</u>	<u>DURATION</u>	<u>SEX</u>	<u>WEIGHT</u>	<u>COMPLICATIONS</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

REVIEW OF SYSTEMS: How have you been feeling RECENTLY?

**A. GENERAL**

- |     |     |  |
|-----|-----|--|
| YES | NO  |  |
| ( ) | ( ) | Recent weight gain or loss exceeding 25 lbs. |
| ( ) | ( ) | Depression                                   |
| ( ) | ( ) | Headaches                                    |
| ( ) | ( ) | Any Problems with eyes, ears or nose         |

**D. GASTROINTESTINAL**

- |     |     |   |
|-----|-----|---|
| YES | NO  |   |
| ( ) | ( ) | Any problems with your digestive system |
| ( ) | ( ) | Bright Blood in stools                  |
| ( ) | ( ) | Clay colored stools                     |
| ( ) | ( ) | Black Stools                            |

**B. CHEST AND HEART**

- |     |     |                                    |
|-----|-----|------------------------------------|
| ( ) | ( ) | Palpitation                        |
| ( ) | ( ) | Skipped or irregular heart beat    |
| ( ) | ( ) | Chest discomfort on exertion       |
| ( ) | ( ) | Chest pain with breathing          |
| ( ) | ( ) | Shortness of breath with exertion  |
| ( ) | ( ) | Awakening at night short of breath |
| ( ) | ( ) | Short of breath lying down         |
| ( ) | ( ) | Coughing up blood                  |

**E. GENITO-URINARY**

- |     |     |                               |
|-----|-----|-------------------------------|
| ( ) | ( ) | Frequent or painful urination |
| ( ) | ( ) | Difficulty holding urine      |
| ( ) | ( ) | Difficulty starting urine     |
| ( ) | ( ) | Change of color of urine      |
| ( ) | ( ) | Blood or pus in urine         |

**C. BREASTS**

- |     |     |                                 |
|-----|-----|---------------------------------|
| ( ) | ( ) | Breast lump                     |
| ( ) | ( ) | Breast tenderness               |
| ( ) | ( ) | Nipple discharge                |
| ( ) | ( ) | Family history of breast Cancer |

Last Mammogram , date if over 40

\_\_\_\_\_

*Drs. Taylor, Cook, Khan, Zertuche, Szabo and De*

Richard J. Taylor, MD  
Nancy H. Cook, MD  
Kathleen S. Khan, MD  
Adrienne D. Zertuche, MD  
Caitlin R. Szabo, MD  
Nidhi S. De, MD  
Courtney F. Adank, PA-C, M.M.Sc.

**PATIENT INFORMATION**  
**PLEASE COMPLETE FULLY**

**PATIENT'S LEGAL NAME:**

Miss Mrs. Ms. \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
(Last) (First) (Middle Initial)

Nickname or Name you wish to be called \_\_\_\_\_ S.S.# \_\_\_\_\_

Res. Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-Mail \_\_\_\_\_ (private e-mail)

Home Phone ( ) \_\_\_\_\_ Bus. Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed Religious Preference \_\_\_\_\_

Please circle the best number to reach you. May we leave a message? YES \_\_\_\_\_ NO \_\_\_\_\_

Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

**SPOUSE'S NAME:** \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_

Spouse's Birthdate \_\_\_\_\_ Contact Phone ( ) \_\_\_\_\_

Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

**IF MINOR, NAME OF PERSON RESPONSIBLE FOR PAYMENT:** \_\_\_\_\_

Relationship to minor \_\_\_\_\_ Res. Address \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ S.S.N. \_\_\_\_\_ D.O.B. \_\_\_\_\_

Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Bus. Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Insurance Company: \_\_\_\_\_ Primary Insured \_\_\_\_\_

Relationship \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Name of Insured \_\_\_\_\_

Relationship \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Patient Referred by \_\_\_\_\_

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DUE TO CONSTANT CHANGES AND VARIETIES OF INSURANCE PLANS, YOU WILL NEED TO PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST EACH TIME YOU VISIT OUR OFFICE. IF YOU DO NOT HAVE YOUR CARD, PLEASE EXPECT TO PAY FOR THAT VISIT. WHEN INSURANCE INFORMATION IS RECEIVED, WE WILL FILE FOR YOU

**RELEASE OF INFORMATION:** I authorize the release of any medical or other information in order to process a claim being filed on my behalf.

**PAYMENT OF INSURANCE BENEFITS:** I authorize payment of benefits directly to Drs. Taylor, Suarez, Cook, Carroll, Khan, and Zertuche when an insurance claim is being filed on my behalf. Any amount not paid by the insurance company is due by me.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

DRS. TAYLOR, COOK, KHAN, ZERTUCHE, SZABO, AND DE  
A Division of Atlanta Women's Healthcare Specialist, LLC

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

We would like to thank you for taking the time to complete this short questionnaire. Due to recent government initiatives, we are now required to collect certain information. Please complete the following information regarding the patient that is being seen today. If you prefer not to share this information, please feel free to choose the "decline to answer" option in each category.

Please choose one from each section.

Race:

- American Indian/Alaskan
- Asian
- Black/African American
- Hawaiian/Pacific Islander
- Multiracial
- White
- Unknown/Unsure
- Decline to answer

Ethnicity:

- Hispanic
- Non-Hispanic
- Unknown/Unsure
- Decline to answer

Preferred Language:

- English
- Other (List preferred language): \_\_\_\_\_
- Decline to answer

**Atlanta Women's Healthcare Specialists, LLC**  
275 Collier Road, NW Atlanta, Georgia 30309

**FINANCIAL POLICY**

**Patient Name:** \_\_\_\_\_  
(Please print)

**Date of Birth:** \_\_\_\_\_

Atlanta Women's Healthcare Specialists (AWHS) providers are committed to meeting your health care needs! We are pleased that you have chosen us. Listed below are our financial policies. If you have any questions, please discuss them with our financial team.

**Patient Responsibility**

1. All co-payments are due at the time of visit. Postdated checks are not accepted.
2. Co-insurance and unmet deductibles are due prior to scheduled office visits, ultrasounds, surgeries, and procedures. Once benefits are verified and my financial responsibility calculated, I will be notified of the payment amount and due date.
3. I am responsible for payment of charges for services I receive from AWHS office. As a convenience, this practice will submit claims for reimbursement with your insurance provider; however, all payment responsibility is ultimately yours.
4. In accordance with my insurance member handbook, it is my responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If I do not have insurance or do not present a valid insurance card, I will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
5. It is my responsibility to ensure that AWHS physicians are in your insurance network.
6. If my plan requires a referral, it is my responsibility to obtain this prior to being seen by our provider.
7. It is my responsibility to notify the office of any changes to your mailing address, phone number(s), email, and insurance information.
8. Failure to divulge or misrepresent all active insurance policies to the practice will result in the full charge amount being your responsibility.
9. Cancellations for appointments and procedure must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time.
10. Payment is due for rendered services 7 days from receipt of your billing statement. Unpaid previous balances must be paid in full prior to any additional visit unless arrangements have been made with our financial counselor.
11. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or check for services rendered at the time of service.
12. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan.
13. **I understand that my signature and payment information will be maintained on file digitally for payment plan arrangements with the practice. The applicable payment card or check information will be truncated & "tokenized" by the payment agent in order to help maintain the security of my payment information. Credit Card or check information will be obtained through a card swipe, manual entry, voided check, or orally in person or over the phone.** I authorize AWHS and/or its designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures or supplies, medical record requests, including (i) amounts agreed as part of a payment plan, (ii) copays, (iii) coinsurance, (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation, or returned check fee.
14. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive monthly statements for any outstanding balance. You are responsible for paying this balance by its due date in order to avoid paying interest on the balance.
15. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address

16. I authorize AWHIS and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

**Fees**

1. The returned check fee is \$30.00.
2. There will be an additional charge of 25% of the balance owed for any past due balance that is submitted to an outside agency for collections.
3. Patients who fail to keep and fail to cancel a scheduled appointment may be charged a \$50.00 No Show Fee. There is a \$200.00 cancellation fee for scheduled surgeries that are cancelled less than 5 business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity.
4. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Georgia. Fees must be received prior to record delivery. Company policy does not allow for medical records to be faxed to patients. Patients can access medical records via the web portal or pick up in person.

When a physician treats you via telephone after hours it is for emergencies only. Therefore, for routine problems that require history, diagnosis and treatment (i.e., calling a prescription or refill into a pharmacy), the provider may bill a \$50 to \$75 service fee.

**Administrative Services**

There is a fee for patient Administrative Services. Our office collects an **OPTIONAL** Administrative Service Fee of \$15.00 annually for Gynecologic visits and \$75.00 per pregnancy for Obstetrical visits (payable at the beginning of the Prenatal Care) which covers all forms that need to be completed during your pregnancy. **YOU ARE NOT REQUIRED TO PAY THIS FEE**; however, if you choose not to pay the fee there is a \$20.00 charge for each required completed form, payable prior to service completion.

This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative item not covered by insurance.

\_\_\_\_\_ (Initial) I accept the Administrative Service Fee. I will pay \$15.00 annually. (GYN)

\_\_\_\_\_ (Initial) I accept the Administrative Service Fee. I will pay \$75.00 today. (OB per pregnancy)

\_\_\_\_\_ (Initial) I decline the Administrative Service Fee, by declining the Administrative Service Fee. I understand that I will be charged \$20.00 for each completed form.

My signature authorizes Atlanta Women's Healthcare Specialists, LLC, to file insurance claims on my behalf to Medicare or other insurance plans and for payments of any benefits due under my insurance plan to be made to Atlanta Women's Healthcare Specialists, LLC, when insurance is filed on my behalf.

*By my signature below, I acknowledge that I have read and understand this Financial Policy.*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

DRS. TAYLOR, COOK, KHAN, ZERTUCHE,  
SZABO, AND DE

275 COLLIER ROAD, SUITE 100-B

ATLANTA, GEORGIA 30309

RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM

I \_\_\_\_\_ HAVE HAD  
AVAILABE TO ME A COPY OF DRS. TAYLOR, COOK,  
KHAN, ZERTUCHE, SZABO AND DE'S NOTICE OF  
PRIVACY PRACTICES.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE