North Georgia OB/GYN Specialists

Dear Patient,

North Georgia OB/GYN Specialists is pleased to announce the introduction of online access to your health information via our secure patient portal. Our portal, Med Fusion, is a secure, web-based system that allows you real-time access to your medical record and enables you to contact our office electronically.

Med Fusion is available to you 24 hours a day for you to review your health records and conduct non-urgent communications with our office. Our staff remains available to you by phone during normal business hours.

Med Fusion Patient Portal provides a convenient way to:

- View many of your lab/test results
- View a summary of your visit
- Review your medical record in a secure environment

Talk with a staff member at 770.926.9229 for more information or visit us at northgaobgyn.com to login!

For support, visit: Support: http://www.medfusion.com/lp/need-help/

Thank you,

North Georgia OB/GYN Specialists

Reorder #33991 PP0090 (NGOS_A) NEW PATIENT PACK

NORTHSIDE HOSPITAL

North Georgia OB/GYN Specialists

Patient Name _____

Date of Birth _____ /_____ /_____
Month Day Year

Name: _____ Age:_____ Date:_____

Reason for Visit: _____

Pharmacy Name and Number: _____

Referred by/Primary Care Physician: _____

Past Medical History (check all that apply):

Blood Clots/DVT _____ Abnormal Pap Smear _____ Epilepsy _____

Hypertension _____ Abnormal Mammogram _____ Diabetes _____

Osteoporosis _____ Breast Cancer _____

Explain: _____

_____

Other Medical History: _____

_____

Date of:	**Result (if abnormal, explain):**
Last Pap Smear: _____	Normal / Abnormal _____
Mammogram: _____	Normal / Abnormal _____
Bone Density: _____	Normal / Abnormal _____
Colonoscopy: _____	Normal / Abnormal _____

Past Surgical History:

_____

_____

Medications: list ALL medications you are currently taking, including dose

(include prescription patches, creams, and over the counter medications)

_____

_____

Allergies: Do you have any drug allergies? N / Yes, please list: _____

_____

Other Allergies: _____

Family History (check all that apply and explain):

List family member and if maternal or paternal

_____Cancer (include type): _____

_____Heart Disease: _____

_____Diabetes: _____

_____Other Family Medical History: _____

_____

Social History:

Do you smoke? _____ If yes, packs per day _____ Do you drink alcohol? _____ How many times in the past year have you had 4 or more drinks in a day? _____ Use illicit drugs? _____

Marital Status: _____ Have you experienced depression or domestic violence? _____ Please explain (confidentiality is guaranteed)_____

_____

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NEW PATIENT VISIT FORM

Reproductive History:

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

If period has stopped, age at last period: _____ Sexually Active? Yes / No

Type of Contraception: _____

Are your period regular? Yes ____ If no, please explain:_____

Do you experience clots while menstruating? No ____ If yes, please explain: _____

Do you have problems with break through bleeding? No ____ If yes, please explain:_____

_____

Are you on Hormone Replacement Therapy? Yes ____ No ____

Total Pregnancies		Full Term Births		Premature Births	
Abortions Ectopic		Miscarriages		Pregnancies	

	First Name	Date of Birth	Birth Weight	M/F	Doctor's Name	Delivery Method	Complications
I							
2							
3							
4							
5							
6							
7							

Please circle all of the symptoms you are CURRENTLY experiencing:

Constitutional	Fatigue	Weight Loss	Weight Gain
	Loss of Appetite		
HENT	Headaches	Thyroid Mass	
Breasts	Lumps	Tenderness	Swelling
	Redness	Nipple Discharge	Changes in Breast Size
Cardiovascular	Chest Pain	Irregular Heart Beat	Limb Swelling
Respiratory	Shortness of Breath	Wheezing	Cough
Gastrointestinal	Nausea	Vomiting	Diarrhea
	Constipation	Abdominal Pain	Hemorrhoids
Genitourinary	Urgency	Frequency	Decreased Libido
	Vaginal Discharge	Possible Pregnancy	Significant PMS
	Difficulty Urinating	Leaking Urine	Pain with Urination
	Menstrual Irregularities	Menstrual Cramping	
Integument/Skin	Rash	Itching	Hair Growth Change
	Changes to Existing Skin Lesions or Moles	Acne	
Musculoskelctal	Joint Pain	Back Pain	Hip Pain
Endocrine	Loss of Hair	Cold Intolerance	Night Sweats
	Hot Flashes		
Psychiatric	Anxiety	Depression	Difficulty Sleeping
Heme-Lymph	Easy Bleeding	Easy Bruising	

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900 Towne Lake Parkway
Suite 404
Woodstock, GA 30189
Phone: 770-926-9229
Fax: 678-445-2164

NORTHSIDE HOSPITAL

North Georgia OB/GYN Specialists

English - Spanish

[OPTIONAL FORM – NOT REQUIRED TO BE COMPLETED]

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____ Date: _____

As a patient, you have the option to designate a spouse, family members, friends, or other persons with whom this practice can communicate with about your health care status. It will be necessary to complete a new form at each Northside medical practice where you receive care. While this form is not required in all circumstances for your doctor or others at Northside to be able to communicate with your family about your health care, designating certain individuals who you want to be informed about your care on this form will ensure that your provider can speak with those people whom you have designated below.

If you anticipate that you will need or want your health information to be verbally provided to your family members, friends or caregivers, please indicate that below so that we may best serve you. By signing below, you authorize the following persons to receive your verbal health information as requested, regarding your care and treatment. Updates to this form must be made in person. Signing this form is entirely voluntary and optional. This form does not authorize release of copies of your health records.

First and Last Name	Relationship:

I understand that this Consent can be revoked by submitting a written request to the Office Manager at the Northside Hospital Physician Office Practice identified at the top of this form. I understand that I have the right to revoke this Consent in writing at any time except to the extent that action has already been taken in reliance on it. This Consent shall remain in effect until the date I revoke it in writing or sign a new form.

_____ _____

Signature of Patient or Legal representative Print name:

_____ AM/PM _____ _____

Date Time Relationship to patient:

_____ _____

Interpreter (if applicable) Reason patient unable to sign:

Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

Please complete this form and return it to the Practice manager.

FOR INTERNAL PURPOSES ONLY:

Date Consent Received:_____

Reorder #33991 PP0090 (NGOS_A) NEW PATIENT PACK

Reorder #26700 PP0033 (NGOS_A)
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NORTHSIDE HOSPITAL PHYSICIAN OFFICE PRACTICE
CONSENT TO COMMUNICATE WITH DESIGNATED INDIVIDUALS

Original - Medical Records
Yellow - Patient