

Southside OB/GYN, P.C.

10025 Ford Avenue, Suite 3-A  
Richmond Hill, Georgia 31324  
912-756-3404

4750 Waters Avenue, suite 450  
Savannah, Georgia 31404  
912-355-9303

Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

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

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Employer \_\_\_\_\_

Spouse \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Spouses Employer \_\_\_\_\_

Emergency contact not living with you \_\_\_\_\_

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Prim. Ins. \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_

Secondary \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

PARENT/GUARDIAN INFORMATION FOR MINOR CHILD

Mother \_\_\_\_\_ Father \_\_\_\_\_

SSN \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Phone (H) \_\_\_\_\_ Phone (H) \_\_\_\_\_

Cell \_\_\_\_\_ Cell \_\_\_\_\_

Work \_\_\_\_\_ Work \_\_\_\_\_

**Labs:** All lab specimens are sent to Labcorp unless you specify another lab in the blank provided here: \_\_\_\_\_

**Checkout notes:** Please stop at the CHECK OUT COUNTER before leaving our office.

**Payments and/or copayments** are due on the day of service. As part of our service we will submit your insurance claims. Insurance information provided, deductibles paid and financial arrangements for procedures/surgeries must be made with our patient relations department prior to the procedure or surgery.

**Release of information and assignment of benefits declaration:** I authorize examination and treatment to the above named patient. I hereby authorize all insurance benefits to be assigned to benefactors of Southside OB/GYN, P.C. I hereby authorize the release of any medical information acquired in the course of my exam and treatment for continuity of care. I understand that I am ultimately responsible for the bill incurred by the above named patient in the event the insurance fails to pay for services rendered.

Patient (Guardian) Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name of Signature \_\_\_\_\_

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Personal History

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Reason for visit \_\_\_\_\_

Pregnancies #: \_\_\_\_\_ Children #: \_\_\_\_\_ Abortions/Miscarriages #: \_\_\_\_\_

Date of last Menstrual Period: \_\_\_\_\_ How often do they occur? \_\_\_\_\_

How long do they last? \_\_\_\_\_ Flow: Light Moderate Heavy

Age when periods first began: \_\_\_\_\_ Current contraception: \_\_\_\_\_

Past surgeries: \_\_\_\_\_

Medications currently using: \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If yes, how much? \_\_\_\_\_ Alcohol? \_\_\_\_\_

Do you or an immediate family member have a history of the following problems/diseases?

PROBLEM	YOU?	WHICH FAMILY MEMBER
Headaches or Migraines	_____	_____
Eyes, Ears, Nose or Throat Prob. (Sinus)	_____	_____
High Blood Pressure, Stroke, Heart Disease	_____	_____
Respiratory Disease (Lungs)	_____	_____
Breast Disease or Breast Cancer	_____	_____
Jaundice or Hepatitis	_____	_____
Gallbladder Disease	_____	_____
Hiatal Hernia, Ulcers or Bowel Disorders	_____	_____
Kidney or Urinary Tract Problems	_____	_____
Anemia or Blood Disorders	_____	_____
Blood Transfusions	_____	_____
Varicose Veins or Phlebitis	_____	_____
Diabetes	_____	_____
Thyroid Disease	_____	_____
Cancer	_____	_____
Epilepsy	_____	_____
Infertility	_____	_____