MOGA
Memphis Obstetrics and Gynecological Association, P.C.

Penn Q. Joe, M.D.
M. Andrea Giddens, M.D.
Elizabeth K. Mann, M.D.
Cory R. Tinker, M.D.
Lea Mary Bannister, M.D.
Claudia L. Moise, M.D.
Elizabeth F. McAdory, M.D.
Lynn G. Kirkland, D.N.Sc., W.H.N.P.
Jennifer B. Fredrickson, M.S.N., F.N.P.
H. Leigh Adkins, M.D. 1923–2016

George F. Wortham, III, M.D.
Crista L. Crisler, M.D.
John F. Albritton, M.D.
Fazal M. Manejwala, M.D.
Elaine A. Thompson, M.D.
Jason B. Mullenix, M.D.
Jason G. Williams, M.D.
Linda W. Childers, M.S.N., F.N.P.
Jennifer Dewey, M.S.N., F.N.P.
William W. Aycock, Jr., M.D. 1949–2012

James A. Wilson, III, M.D.
G. Aric Giddens, M.D.
Peter L. Ballenger, M.D.
Michael F. Counce, M.D.
Alok Kumar, M.D.
Helena G. Shannon, M.D.
Daniel A. Lee, M.D.
Kelly K. Pfrommer, M.S.N., F.N.P.
John Overton Gayden, M.D., Emeritus

Established MOGA Patients

We realize that your time is very valuable, so we ask that you complete this paperwork and bring with you to your scheduled appointment.

Did You Know?

MOGA offers **3-D screening mammography** at our East, Wolfchase, and Germantown locations and **2-D screening mammography** at our Desoto location. MOGA also offers **bone density scanning** at our East, Germantown, and Wolfchase locations. **If you are due for either of these tests, please make sure to schedule them conveniently at the time of your appointment.**

Additionally, on the day of your appointment, we ask that you **arrive fifteen minutes early**. Please bring your **insurance card**, a **photo ID** (example: driver's license), your **pharmacy phone number**, and any applicable **co-pay, deductible, or co-insurance**.

We look forward to seeing you!

At MOGA, it is our mission to serve as a leader and premier provider of women's healthcare services for the mid-south community by continuously learning, growing, and partnering with our patients, employees, and other healthcare providers. As we strive to achieve excellence on a daily basis, it is our commitment to deliver the highest level of quality and compassion to every patient.

MOGA

Memphis Obstetrics and Gynecological Association, P.C.

Delivering Excellence for Over 30 Years

PATIENT #	
DATE	
DOCTOR	
EMPLOYEE NAME	

PATIENT INFORMATION

Please complete all blanks

PATIENT

NAME LAST	FIRST	M.I.	AGE	DATE OF BIRTH	ARE YOU PREGNANT?
					☐ YES ☑ NO

ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	EMAIL ADDRESS

SOCIAL SECURITY NO.	MARITAL STATUS	HAVE YOU BEEN TREATED BY THESE PHYSICIANS BEFORE?	UNDER WHAT NAME	DATE
	☑ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED	☐ YES ☑ NO		

OCCUPATION	NAME OF EMPLOYER OR SCHOOL	WORK PHONE

ADDRESS	CITY	STATE	ZIP

RACE (for Multi-Racial, please check ALL that apply)

☐ AMERICAN INDIAN / ALASKA NATIVE ☐ ASIAN ☐ PACIFIC ISLANDER / NATIVE HAWAIIAN

☐ BLACK / AFRICAN-AMERICAN ☐ WHITE ☐ UNKNOWN / DECLINED TO REPORT

ETHNICITY

☐ HISPANIC / LATINO

☐ NON-HISPANIC / NON-LATINO

☐ UNKNOWN / DECLINED TO REPORT

PREFERRED LANGUAGE

☐ ENGLISH ☐ SPANISH; CASTILIAN

☐ DECLINED TO REPORT

☐ OTHER_____

HOW DID YOU HEAR ABOUT MOGA?

PREFERRED PHARMACY: NAME	TEL.#	DO YOU HAVE AN ADVANCE DIRECTIVE?
		☐ YES ☐ NO

WHO IS YOUR PRIMARY CARE PHYSICIAN? NAME	ADDRESS	PHONE

IN CASE OF EMERGENCY NOTIFY:	NAME	STREET ADDRESS, CITY, STATE & ZIP CODE	PHONE

INSURANCE POLICYHOLDER INFORMATION

NAME	ADDRESS	PHONE

SOCIAL SECURITY NO.	OCCUPATION	NAME OF EMPLOYER	DATE OF BIRTH

EMPLOYER'S ADDRESS	CITY	STATE	ZIP	PHONE

INSURANCE

PRIMARY INSURANCE	MAIL FORM TO: STREET ADDRESS	CITY	STATE	ZIP	PHONE

POLICY HOLDER (IF GROUP, EMPLOYER)	INSURED'S NAME	RELATIONSHIP TO INSURED	☐ GROUP ☐ PRIVATE	POLICY OR I.D.#	GROUP OR OTHER NO.
		☐ SELF ☐ CHILD ☐ WIFE ☐ HUSBAND			

SECONDARY INSURANCE	MAIL FORM TO: STREET ADDRESS	CITY	STATE	ZIP	PHONE

POLICY HOLDER (IF GROUP, EMPLOYER)	INSURED'S NAME	RELATIONSHIP TO INSURED	☐ GROUP ☐ PRIVATE	POLICY OR I.D.#	GROUP OR OTHER NO.
		☐ SELF ☐ CHILD ☐ WIFE ☐ HUSBAND			

PLEASE READ AND SIGN

AUTHORIZATION—I hereby give my permission to Memphis Obstetrics and Gynecological Association, PC (MOGA) for medical treatment including but not limited to examination, injections, blood tests, diagnostic testing, or medical procedures deemed necessary and appropriate for diagnosis and treatment. I authorize MOGA to release any information concerning my treatment and irrevocably assign to them all insurance benefits for my treatment. I understand that I am financially responsible for payment of all charges at the time they are rendered including any changes in excess of my insurance as reasonable and customary, whether or not covered by Medicare or other insurance. I understand that I am responsible for verifying my insurance coverage and pre-certifying my benefits with my insurance company. I also understand that I am responsible for 33% collection costs and/or attorney fees incurred in the collection of this account. A photocopy of this statement is considered to be as valid as an original.

☐ **Signed:**_____ **Date:** _____

MEMPHIS OBSTETRICS & GYNECOLOGICAL ASSOCIATION, P.C.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO OBTAIN THIS INFORMATION. PLEASE REVIEW CAREFULLY. YOU HAVE THE RIGHT TO OBAIN A COPY OF THIS NOTICE UPON REQUEST.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We are permitted by law to use and disclose patient health information for treatment, payment, and healthcare operations.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other healthcare providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Healthcare Operations. We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcome of your case and others similar to it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use and disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information about you for the following purposes:

Required by Law: We are required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent serious threat to the health and safety of you, another person, or the public.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Research: We may use or disclose information for approved medical research.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

In any other situation, we will require written authorization before using or disclosing any protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Revocation requests must be made in writing and submitted to the clinic's Privacy Officer.

You have the following rights with regard to your health information. Please contact our office to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by them.
Confidential Communications: You may ask us to communicate confidentially by, for example, sending notices to a special address or not calling with appointment reminders.
Inspect and Obtain Copies: In most cases, you have the right to look at or obtain a copy of your health information. There may be a charge for the copies.
Amend Information: If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the existing information or add the missing information. We are not required to agree to such amendment, but must let you know our reasons.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. Upon request, you may receive a copy of this notice.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You may also request a copy of our Notice at any time. For more information about our privacy practices, contact our Privacy Officer.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we have made about your records, please contact our Privacy Officer. You may also send a written complaint to the U.S. Department of Health and Human Services. The Privacy Officer will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person / Privacy Officer
If you have any questions, complaints, or requests, please contact:

Stephanie Wheeler	Ami Jennings
3775 Covington Pike	6215 Humphreys Blvd # 401
Memphis, TN 38119	Memphis, TN 38120
(901) 202-6122 or swheeler@clearlymd.com	(901) 767-8442, ext 2020 or ajennings@spsmemphis.com

This Notice became effective April 14, 2003, and was revised on February 7, 2017.

MEMPHIS OBSTETRICS & GYNECOLOGICAL ASSOCIATION, P.C. (MOGA) – FINANCIAL & ADMINISTRATIVE POLICIES

RECEIPT OF PRIVACY PRACTICES

- I acknowledge that I have received or been allowed to view a copy of MOGA's Notice of Privacy Practices as required by HIPAA. This notice describes how MOGA may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Initial _____

DISCLOSURE OF TENNCARE COVERAGE

- By initialing you are certifying **one** of the following:
  - ☐ **NO, I do NOT have** active or pending TennCare coverage
  - ☐ *YES, I DO have* active or pending TennCare coverage

Initial _____

PATIENT PAYMENT POLICY AND COVERED SERVICES

- It is the policy of MOGA to collect all patient balances, co-pays, and deposits due from patients at the time of service.
- If you are being seen for maternity care or for certain other surgical or medical procedures, our office may contact your insurance carrier to verify your insurance coverage and benefits. An estimation of your financial responsibility will be determined according to the contractual agreement between MOGA and your insurance company for these services. Our Benefits Coordinators will review your benefits with you to explain your financial obligations to MOGA, and you may be required to pay a deposit prior to these services being rendered.
- If your insurance claim is denied due to incorrect personal information or incorrect insurance information that you have provided, you will be billed for any unpaid claims for your services, and payment in full will be due immediately.
- If your account or any account for which you are responsible is sent to a collection agency due to non-payment of any patient balance, you may be dismissed from MOGA for any future care and services, which includes all providers at MOGA. Additionally, a collection fee of 33% will be added to your account balance.
- Your health insurance plan **may not** provide coverage for all medical services, tests, and/or procedures that our providers may offer or recommend for your treatment. It is your responsibility to know and understand the services covered by your insurance, and if your insurance does not cover these services, you will be responsible for payment.
- If you do not have medical coverage with an insurance for which MOGA participates or if you are a new patient and cannot supply your valid insurance card or for which coverage cannot be determined, you must pay in full at the time of service.
- Certain labs collected in this office may be sent to an outside lab for testing. As such, you may be billed by that reference lab for these.
- If you are required to have a referral or other prior authorization for medical services, it is your responsibility to obtain this.
- WE will require that accounts with self-pay balances to pay their balances to zero (0) prior to receiving further services by our practice.

Initial _____

RETURNED CHECK CHARGE

- MOGA will charge the patient account $25.00 for any returned checks to cover MOGA's cost for any related bank charges.

Initial _____

CANCELLATION POLICY

- MOGA requires a 24 hour cancellation notice for any scheduled medical appointment or surgery/procedure.
- No shows and cancellations without a 24-hour notice may receive a $20.00 charge for missed office visits and $150.00 for missed surgeries or procedures. This charge will be the patient's responsibility and will not be billed to or reimbursed by your insurance.
- If a patient repeatedly misses or cancels appointments, the patient may be dismissed from the practice.

Initial _____

WELLNESS/ANNUAL VISITS WITH OTHER PROBLEMS

- If during your annual/well-woman preventive care exam, you have or need treatment for a problem, if the problem is addressed during the visit in lieu of scheduling a separate appointment, in addition to the preventive exam it may be necessary that a problem/E&M visit be billed along with other labs, testing, and/or procedures, which may be subject to copays and/or deductible.

Initial _____

PERSONAL INFORMATION VERIFICATION

- It is our policy to verify your demographic and insurance information **at every visit** to help insure that claims are processed timely and accurately. Although it may seem unnecessary at the time, this is extremely important to our billing process. Please bring your insurance card with you **EVERY VISIT**. Additionally, a photo ID will be requested from all patients.

Initial _____

FORMS AND PAPERWORK

- There is a minimum fee of $20.00 for the release of medical records which is the responsibility of the patient to pay prior to receiving the records. For records that exceed twenty (20) pages, there may be an additional charge of $0.50 per page for all pages exceeding the first twenty (20) pages. A $20.00 fee will be charged to complete up to two (2) forms for FMLA and standard disability. An additional fee of $25.00 will be charged for submitting subsequent forms.

Initial _____

Patient Signature _____ Patient Printed Name _____

Date _____ Patient Chart #_____ MOGA Initials_____ eff: 12/15/16

MOGA
Memphis Obstetrics and Gynecological Association, P.C.

Penn Q. Joe, M.D.
M. Andrea Giddens, M.D.
Elizabeth K. Mann, M.D.
Cory R. Tinker, M.D.
Lea Mary Bannister, M.D.
Claudia L. Moise, M.D.
Elizabeth F. McAdory, M.D.
Lynn G. Kirkland, D.N.Sc., W.H.N.P.
Jennifer B. Fredrickson, M.S.N., F.N.P.
H. Leigh Adkins, M.D. 1923–2016

George F. Wortham, III, M.D.
Crista L. Crisler, M.D.
John F. Albritton, M.D.
Fazal M. Manejwala, M.D.
Elaine A. Thompson, M.D.
Jason B. Mullenix, M.D.
Jason G. Williams, M.D.
Linda W. Childers, M.S.N., F.N.P.
Jennifer Dewey, M.S.N., F.N.P.
William W. Aycock, Jr., M.D. 1949–2012

James A. Wilson, III, M.D.
G. Aric Giddens, M.D.
Peter L. Ballenger, M.D.
Michael F. Counce, M.D.
Alok Kumar, M.D.
Helena G. Shannon, M.D.
Daniel A. Lee, M.D.
Kelly K. Pfrommer, M.S.N., F.N.P.
John Overton Gayden, M.D., Emeritus

I hereby authorize this office to release my protected health information (PHI), including account status, test results, scheduled appointments, and information regarding my treatment, to the persons I have listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Any person who is not listed above will not be able to obtain my protected health information (PHI). It is not necessary to list other treating physicians or insurance companies.

PHI Patient Communication:

When notifying me of lab or test results, matters relating to prescriptions, appointments and accounts status the practice may call:

_____Hm _____ Cell _____Other

May the practice leave you a message at the above phone numbers? ☐ Yes ☐ No

Mail to: _____

_____

Patient Signature: _____ **Date:** _____

Patient's Acct # _____

MOGA – Memphis Obstetrics and Gynecological Association, P.C.

CONFIDENTIAL PATIENT MEDICAL HISTORY

Name:_____ Birthdate:_____ Chart # _____ Date: _____

Allergies: _____

Do you have a **LATEX Sensitivity / Allergy**: Yes: □ No: □ **Other Allergies** (circle): Iodine, X-ray dye, Eggs, Peanuts

MEDICATIONS: Please list ALL medications that you take, the strength, and how often you take them

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PHARMACY (Name and Number): _____

IMMUNIZATIONS: Please check if you have received these adult immunizations and indicate when

□ Influenza (Flu) / Date:	□ Tetanus / Date:
□ Pneumonia / Date:	□ Tdap (Tetanus, Diptheria & Pertussis)/ Date:
□ HPV Vaccine/Gardasil (Series of 3 shots – Initial shot, 2 months later, then 6 months from 1st shot) Dates (Approx. date is ok): #1 _____ #2 _____ #3 _____	

HEALTH MANAGEMENT: Date and Location of last preventative screenings

Last **Pap Smear**: Date:_____ Location: _____
Last **Mammogram**: Date: _____ Location: _____
Last **Complete Physical Exam with Primary MD**: Date: _____ Provider Name: _____
Last **DEXA Scan** (**Bone Density**): Date: _____ Location: _____
Last **Colonoscopy**: Date: _____ Provider Name: _____

FAMILY HISTORY: Check illnesses of your **IMMEDIATE BLOOD RELATIVES** and **LIST THE RELATION**

□ Adopted: Family history unknown	Cancer: (please list relative)	
□ Heart Disease / list details	□ Breast: _____	□ Cervical: _____
□ Early Death / relation:	□ Colon: _____	□ Uterine: _____
□ High Cholesterol /relation:	□ Ovarian: _____	□ Other: _____
□ High Blood Pressure /relation:	□ Stroke / list details:	
□ Asthma / relation:	□ Seizure Disorder / type & relation:	
□ Diabetes / relation:	□ Alcoholism /relation:	
□ Thyroid Disease / type & relation:	□ Drug Abuse / relation:	
□ Gastrointestinal Disorder / list details:	□ Birth Defects/Genetic Disease /type & relation:	
□ Osteoporosis / relation:	Other Family History:	
□ Blood or Clotting Disorder / type & relation:		

SOCIAL HISTORY: Provide the following information about **YOURSELF**

Do you exercise regularly?_____ How Often?	Do you drink alcoholic beverages? □ Yes □ No If yes, how much? _____
Marital Status: (circle one) □Single□Marriec□Widowed□Divorced□Separated	Do you use recreational drugs? □ Yes □No If yes, which one(s) and how often? _____
Are you sexually active? □ Yes □ No	
Work Status: (circle one) □Part-time□Full-time□Retired□Unemployed□Disabled	Do you take herbal supplements or vitamins? □Yes □No If yes, list: _____
Occupation: _____	Are you currently in a situation or relationship that makes you feel unsafe or threatened? □Yes □No If yes, explain _____
Tobacco or Cigarette Use: □ Never Smoked □ Former Smoker - Date Quit _____ □ Current Smoker - # per day ____ # of years_____ □ Other: _____	

MOGA – Memphis Obstetrics and Gynecological Association, P.C.

CONFIDENTIAL PATIENT MEDICAL HISTORY

Name:_____ Birthdate:_____ Chart # _____ Date: _____

PAST MEDICAL HISTORY: Please check illnesses or conditions **YOU** have had.

Do you refuse blood products or medical treatment of any kind because of religious beliefs? ☐ Yes ☐ No If yes, specify _____	
Birth Control Method _____	☐ **Eye Disease** _____
# of Pregnancies: _____ Living Children:_____	**Heart Disease**:
Deliveries: Vaginal: ____ C-Section(s):____ VBAC #____	☐Atrial Fibrillation ☐Congestive Heart Failure ☐CAD
Miscarriages: _____ Abortions: _____	☐High Cholesterol ☐High Blood Pressure (HTN)
☐ Infertility	**Lung Disease**: ☐Asthma ☐COPD ☐Pneumonia
Age of first period _____	Do you use a CPAP machine for sleep apnea? ☐ Yes
Age of Menopause _____	**Kidney Disease:** ☐ Kidney Stones ☐ Other_____
Menses: (**only complete if still having periods**) ☐ Regular (21-35 days apart) ☐ Irregular Duration of menses: _____ days Menstrual Flow: ☐ Mild ☐ Moderate ☐ Severe ☐ Dysmenorrhea (Painful Periods)	**Gastrointestinal Disorders**: ☐ Celiac Disease ☐ Cirrhosis ☐ Crohn's Disease ☐ Diverticulitis ☐ GERD (Reflux) ☐ Hepatitis ☐ Irritable Bowel ☐ Ulcerative Colitis ☐ Other (specify): _____
☐ Uterine Fibroids ☐ Uterine Disorder _____	**Musculoskeletal**:
☐ Abnormal Pap Smear Date: _____	Arthritis: ☐ Osteo Arthritis ☐ Rheumatoid Arthritis
☐ Colposcopy/Date: _____ ☐ Cryo/Date: _____	☐ Osteopenia ☐ Osteoporosis ☐ Other _____
☐ LEEP/Date: _____ ☐ CKC/Date: _____	☐ Blood Clots in legs /DVT ☐ PE (clot in lung) ☐ Phlebitis
Infection(s): ☐Chlamydia ☐Gonorrhea ☐Herpes ☐HIV	☐ Blood Transfusion: Date(s): _____
☐ Breast Problems (specify) _____	Sickle Cell : ☐ Trait ☐ Disease
Cancer: Breast Ovarian ☐Uterine ☐Colon	**Psychological:** ☐Anxiety ☐Bipolar ☐Depression ☐ADD
☐ Other Cancer(specify) _____	**Neurological**: ☐ Seizure Disorder / Epilepsy ☐ Stroke
☐ Diabetes	☐Chicken Pox (Disease) **or** ☐ Had Vaccine
☐ **Thyroid Disorder**: ☐Goiter ☐Underactive ☐Overactive	Autoimmune Disorder: Lupus ☐ Other _____
Other History or Hospitalizations:	

SURGICAL HISTORY: Please check operations or procedures and **provide dates (**month and/or year is fine**)**

☐ Ear, Nose, Throat Surgery:_____	☐ Bladder or Kidney Surgery _____
☐ Adenoids_____ ☐ Tonsilectomy _____	☐ Bladder sling ☐ Bladder Suspension Surgery
☐ Thyroid Surgery: _____	**Female/Gynecological Surgeries**:
☐ Lung Surgery _____	☐ C-Section (#) ___ ☐Tubal Ligation ☐Pelvic Laparoscopy
☐ Heart Surgery ☐ Stents ☐ Bypass	☐ D&C ☐ Hysteroscopy ☐ Uterine Ablation
Breast Surgery: ☐ Biopsy, R / L ☐ Lumpectomy, R / L ☐ Mastectomy, R / L ☐ Reduction ☐ Augmentation	Hysterectomy: ☐ Abdominal ☐ Vaginal ☐ Supracervical ☐ Laparoscopic / Robotic
Abdominal Surgery: ☐ Appendix ☐ Abdominoplasty ☐ Gallbladder ☐ Hernia Repair ☐ Bariatric Sgy._____	Ovary(s) Removed: ☐ Left ☐ Right ☐ Both Other Ovarian Surgery: _____
☐ Orthopedic Surgery (list type of surgery and date): _____	Other Surgeries or Hospitalizations: _____

LIST OTHER HEALTH CARE PROVIDERS YOU CURRENTLY SEE (other than MOGA)

Provider Name	Specialty (ie: PCP, Cardio)	Phone Number:

Please Sign and Date:

Patient Signature: _____ Date:_____