

Garland D. Scott, M.D.

Obstetrics and Gynecology



1100 E Michigan - Suite 204
Jackson, Michigan 49201

Telephone (517) 787-0072
Fax (517) 787-1988

WELCOME TO WOMEN'S ALLIANCE OF JACKSON, INC.

OUR OFFICE TELEPHONE HOURS ARE 8:00AM - 12 NOON AND 1:00PM - 4:30PM, MONDAY, TUESDAY, THURSDAY AND FRIDAY. WEDNESDAY TELEPHONE HOURS ARE 8:00AM-12 NOON AND 1:00PM-3:00PM.

IN ORDER THAT WE MAY SERVE YOU BETTER, PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT:

- ✓ ENCLOSED FORMS. PLEASE FILL OUT COMPLETELY. IF YOU ARE A MINOR, YOUR PARENTS MUST COMPLETE THEM, GIVING US WRITTEN CONSENT FOR YOUR TREATMENT.
- ✓ ALL MEDICAL RECORDS PERTINENT TO THIS VISIT. PLEASE CALL YOUR REFERRING DOCTOR TO OBTAIN COPIES OF YOUR RECORDS PRIOR TO YOUR APPOINTMENT WITH US.
- ✓ INSURANCE CARDS AND PHOTO ID. IF YOU HAVE INSURANCE THAT WE DO NOT PARTICIPATE WITH, OR IF YOU DO NOT HAVE OFFICE VISIT COVERAGE, PAYMENT FOR SERVICES IS EXPECTED AT THE TIME OF YOUR VISIT. SOME INSURANCES REQUIRE AN AUTHORIZATION FROM YOUR PRIMARY CARE PHYSICIAN. IF YOU ARE UNSURE OF A NEED FOR A PRIOR AUTHORIZATION, PLEASE CONTACT YOUR PRIMARY CARE PHYSICIAN OR INSURANCE COMPANY. ***IT IS YOUR RESPONSIBILITY TO GET AUTHORIZATION.***

DUE TO THE LENGTH AND NATURE OF OUR APPOINTMENTS, WE ASK THAT YOU DO NOT BRING CHILDREN WITH YOU TO THE OFFICE. IF YOU CANNOT KEEP YOUR APPOINTMENT WITH US, PLEASE CALL OUR OFFICE 24 HOURS IN ADVANCE.

SHOULD YOU HAVE A MEDICAL QUESTION THAT NEEDS TO BE DIRECTED TO THE NURSING STAFF OR PHYSICIANS, PLEASE CALL OUR OFFICE AT (517) 787-0072. A MESSAGE WILL BE TAKEN AND A RETURN CALL WILL BE MADE AS SOON AS POSSIBLE, WITHIN THE NEXT 24 HOURS. WE ***TRY*** TO RETURN ALL CALLS AFTER WE HAVE FINISHED WITH PATIENTS FOR THE DAY. FOR PRESCRIPTION REFILLS, PLEASE LEAVE A MESSAGE WITH YOUR NAME, THE PRESCRIPTION AND THE NAME OF THE PHARMACY YOU WOULD LIKE US TO CALL. PLEASE ALLOW UP TO 24 HOURS FOR A RESPONSE.

IN CASE OF AN EMERGENCY, WE CAN BE REACHED 24 HOURS A DAY AT (517) 787-6500. CALLS MADE AFTER HOURS WILL BE DIRECTED TO OUR ANSWERING SERVICE, OR YOU WILL BE GIVEN INSTRUCTIONS TO PROCEED TO FOOTE HOSPITAL, DEPENDING ON THE CIRCUMSTANCES.

WE LOOK FORWARD TO MEETING YOU!

THE STAFF OF WOMEN'S ALLIANCE OF JACKSON, INC.

Garland D. Scott, M.D.

Obstetrics and Gynecology

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Jackson, Michigan 49201



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WE ARE PLEASED TO WELCOME YOU TO WOMEN'S ALLIANCE OF JACKSON, INC. FOR YOUR OBSTETRICAL CARE. OUR STAFF IS DEDICATED TO PROVIDING YOU THE BEST POSSIBLE CARE TO MAKE YOUR PREGNANCY A PLEASANT EXPERIENCE. DURING YOUR FIRST VISITS WE WILL SHARE WAYS THAT WE CAN WORK TOGETHER TO OBTAIN THAT OUTCOME.

YOUR FIRST VISIT WILL BE A MEDICAL ASSISTANT CONSULTATION. DURING THIS VISIT THE MEDICAL ASSISTANT WILL BE ASKING SOME QUESTIONS CONCERNING THE MEDICAL HISTORY OF YOU AND THE BABY'S FATHER. PLEASE TAKE SOME TIME WITH BOTH FAMILIES TO GO OVER THE FOLLOWING:

HISTORY PERTAINING TO YOU ONLY

- ❖ ALLERGIES
- ❖ PHLEBITUS (BLOOD CLOTS)/VARICOSTITIES(VARICOSE VEINS)/DVT(DEEP VEIN THROMBOSIS)
- ❖ TRANSFUSIONS
- ❖ OPERATIONS
- ❖ URINARY TRACT INFECTIONS/KIDNEY DISEASE

HISTORY PERTAINING TO YOU, FATHER OF BABY AND YOUR FAMILIES
(PLEASE INCLUDE PARENTS, GRANDPARENTS, AUNTS, UNCLAS AND COUSINS ONLY)

- ❖ HYPERTENSION
- ❖ TUBERCULOSIS
- ❖ RHEUMATIC FEVER
- ❖ HEART DISEASE OR HEART ATTACKS
- ❖ DIABETES
- ❖ THYROID DISEASE
- ❖ SEIZURES
- ❖ MIGRAINES
- ❖ ANEMIA OR BLEEDING TENDENCIES
- ❖ RHEUMATOLOGIC DISEASE INCLUDING LUPUS
- ❖ DEPRESSION OR ANY PSYCHIATRIC ILLNESS
- ❖ CANCER
- ❖ BREAST DISEASE
- ❖ MULTIPLE BIRTHS
- ❖ BIRTH DEFECTS
- ❖ GENETIC DISORDERS
- ❖ OTHER

KNOWING THESE GENETIC PREDISPOSITIONS CAN HELP ANTICIPATE SOME OF THE AREAS THAT MAY NEED CAREFUL OBSERVATION SO THAT THE HEALTH OF YOU AND YOUR BABY ARE NOT COMPROMISED. THANK-YOU FOR YOUR TIME AND EFFORTS. WE LOOK FORWARD TO MEETING YOU.

Garland D. Scott, M.D.

Obstetrics and Gynecology

Foot Health Center
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Jackson, Michigan 49201



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To My Patients:

I share a regular duty-call rotation for night and weekend coverage of the obstetrical requirements of my patients with Dr. Gary Farhat, Dr. Rajan Pastoriza, Dr. Micheal McDonnell, and Dr. Arthur Vendola, who are Board Certified Obstetrician-Gynecologists.

Please note by signing below that you understand the above information and agree to continue care on said basis.

Sincerely

Garland D. Scott, M.D.

I have read the foregoing message, understand same, and consent that my continued care shall be on said basis.

Date

Signature

WITNESS:

STANDARD CONSENT FORM-THE HUMAN IMMUNODEFICIENCY VIRUS TEST

The HIV test looks for infection with the AIDS virus. I understand that if this test shows I have the AIDS virus, I am most probably infected and could give the AIDS virus to someone else. I could pass the virus to someone I am having sex with, someone I am sharing needles with, or to my unborn baby if I am pregnant. If the test shows I do not have the AIDS virus, I understand I still might have the AIDS virus but it is too early to tell by blood test.

I understand that the information from my test will help me and my health care worker make important choices. If I do not have the AIDS virus, it will help me know how to keep from catching it or if I need another test. If I have the AIDS virus, it will help me know how to take care of myself and how to keep from passing the AIDS virus to someone else.

I understand that Michigan has laws to keep my HIV test information and other health information from being given to anyone else without my written approval. By agreeing to take this test, I understand my test information will not be shared with anyone else unless I say it is okay, in writing, except when the law says it is necessary to share my information with someone who needs to know it.

I understand I can change my mind about taking this test at any time before the test is done. I also understand I have a right to request this test be done without anyone knowing my name.

I understand I should return here to get my test information and talk about my test and if I do not come back, someone may try to get in touch with me to talk about my test.

I understand that after I sign this form, I cannot sue my testers for not making sure I know what this test is all about.

I have been given an information booklet on HIV testing. I understand what the HIV test is, what I might gain or lose from it, and the meaning of the test information. I also understand that I should ask all my questions before the test is done. I also have a copy of this signed form.

I AGREE TO BE TESTED FOR THE HUMAN IMMUNODEFICIENCY VIRUS.

Patient/Parent/Guardian (Please Print)

Relationship, if not patient

Patient/Parent/Guardian (Signature)

Date

Witness Signature

Date

AT THIS TIME, I DO NOT WANT TO BE TESTED FOR THE HUMAN IMMUNODEFICIENCY VIRUS.

Patient/Parent/Guardian (Please Print)

Relationship, if not patient

Patient/Parent/Guardian (Signature)

Date

Witness Signature

Date

ORIGINAL

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COMMONLY ASKED QUESTIONS IN PREGNANCY

MEDICATIONS

DURING PREGNANCY IT IS BEST TO AVOID THE USE OF MEDICATIONS IF POSSIBLE. HOWEVER, DISCOMFORTS MAY OCCUR DURING PREGNANCY NECESSITATING MEDICATION. NOT ALL OVER THE COUNTER MEDICATIONS CAN BE USED IN PREGNANCY. WE HAVE COMPILED THE FOLLOWING LIST OF MEDICATIONS WHICH YOU MAY USE, **AFTER YOU HAVE COMPLETED YOUR FIRST TRIMESTER**. IF A MEDICATION IS NOT INCLUDED IT SHOULD NOT BE TAKEN UNLESS THE PHYSICIAN APPROVES IT.

COLDS/CONGESTION/ALLERGIES:

YOU MAY WANT TO TRY SOME NON-MEDICINAL REMEDIES FOR THE DISCOMFORTS OF A COLD/STUFFY NOSE. OBVIOUSLY, AS WITH ANY ILLNESS, EXTRA REST IS NEEDED ALONG WITH INCREASED INTAKE OF FLUIDS. YOU MAY BENEFIT FROM EXTRA MOISTURE IN THE AIR FROM A VAPORIZER. DRINKING HOT TEA OR BROTH MAY HELP OPEN NASAL PASSAGES AS WELL AS PROVIDE FLUID. A SORE THROAT OR COUGH MAY BE RELIEVED WITH THROAT LOZENGES OR COUGH DROPS. IF THESE MEASURES DO NOT PROVIDE ENOUGH RELIEF YOU MAY TRY ONE OF THE FOLLOWING OVER THE COUNTER MEDICATIONS, **AFTER YOU HAVE COMPLETED YOUR FIRST TRIMESTER**. IF YOU DEVELOP A FEVER OR OTHER SYMPTOMS OF INFECTION YOU NEED TO CALL YOUR PRIMARY CARE PROVIDER OR OUR OFFICE.

AFRIN, ALLEREST, BENEDRYL, CHLOR-TRIMETON, COLD CONTROL+, CONTAC, CORICIDIN (PLAIN ONLY), DRISTAN COLD & FLU, DRIXORAL (NON-DROWSY FORMULA), MEDI-FLU & MEDI-FLU w/OUT DROWSINESS, NOVAHISTINE DMX, OMES (REG OR MAXIMUM STRENGTH), SINE-OFF, SINGLET, SINUTAB, SUDAFED, TELDRIN, THEREFLU, TYLENOL AND VICKS PRODUCTS.

COUGH

BENYLIN, CHERACOL-D, ROBITUSSIN, DIMATAP, AND VICKS FORMULA 44

BODY ACHES/PAIN

YOU MAY OBTAIN SIGNIFICANT RELIEF FROM REST AND A SOOTHING BATH OR SHOWER. IF GREATER RELIEF IS NEEDED YOU MAY TRY ANY OF THE FOLLOWING BRANDS OF ACETAMINOPHEN.

DATRIL, PANADOL, TYLENOL OR ANY GENERIC OR STORE BRAND ACETAMINOPHEN

NAUSEA AND/OR VOMITING

EATING SMALL AMOUNTS OF FOOD FREQUENTLY, AVOIDING FATTY AND SPICY FOODS, AND TAKING FLUIDS SEPARATELY FROM MEALS TO AVOID OVER FILLING THE STOMACH MAY ALLEVIATE THIS COMMON COMPLAINT OF PREGNANCY. OFTEN STARCHY FOODS SUCH AS CRACKERS, BREADS, PASTA, AND RICE HELP SETTLE THE STOMACH. HERBAL TEAS SUCH AS CHAMOMILE, GINGER OR PREGNANCY TEA MAY ALSO PROVIDE RELIEF FROM NAUSEA. IF THESE MEASURES DO NOT PROVIDE ENOUGH RELIEF YOU MAY TRY ANY OF THE MEDICATIONS LISTED BELOW.

BONINE, DRAMAMINE, EMETROL MARAZINE, AND UNISOM

HEARTBURN

HEARTBURN MAY BE RELIEVED BY EATING SMALL PORTIONS FREQUENTLY RATHER THAN 3 LARGE MEALS DAILY. DO NOT DRINK A LOT OF FLUID WITH YOUR MEALS. YOU SHOULD ALSO AVOID LYING DOWN IMMEDIATELY AFTER EATING. SPICY FOODS OR THOSE CONTAINING CAFFEINE MAY CAUSE MORE DISCOMFORT AND MAY NEED TO BE AVOIDED. IF HEARTBURN IS A PROBLEM AFTER THESE MEASURES YOU MAY TRY THE FOLLOWING ANTACIDS:

GAVICON, GELUSIL, MAALOX, MYLANTA, RIOPAN, ROLAIDS, AND TUMS

CONSTIPATION

CONSTIPATION MAY BE AVOIDED BY EATING A DIET RICH IN FRESH FRUITS AND VEGETABLES AND WHOLE GRAINS ALONG WITH PLENTY OF FLUIDS. THE BEST NATURAL LAXATIVE IS OFTEN PRUNES OR PRUNE JUICE. YOU MAY ALSO TRY ANY OF THE FOLLOWING BULK LAXATIVES.

CITRUCEL, COLACE, DIALOSE, DULCOLAX, FIBERALL, FIBERCON, SURFAK, AND METAMUCIL.

HEMORRHOIDS

PREVENTION OF CONSTIPATION IS ON WAY OF PREVENTING HEMORRHOIDS. DESPITE THESE EFFORTS SOME WOMEN WILL DEVELOP HEMORRHOIDS IN PREGNANCY. THE FOLLOWING REMEDIES MAY PROVIDE RELIEF IN THIS EVENT.

AMERICAINE OINTMENT, ANUSOL CREAM, NUPERCAINAL, PREPERATION H, TRONOLANE, AND TUCKS PADS OR CREAM

EXERCISE

ANOTHER COMMON QUESTION OF PREGNANT WOMEN IS "CAN I EXERCISE?" IF YOU DO NOT HAVE RESTRICTIONS FOR OTHER MEDICAL CONDITIONS AND IF YOU DO NOT HAVE COMPLICATIONS IN YOUR PREGNANCY, YOU MAY CONTINUE TO ENGAGE IN EXERCISE TO WHICH YOU ARE ACCUSTOMED. DURING EXERCISE YOU SHOULD MONITOR YOUR HEART RATE TO ASSURE THAT IT REMAINS BELOW 140 BEATS PER MINUTE. NEVER EXERCISE TO THE POINT OF EXHAUSTION OR ALLOW YOURSELF TO BECOME OVERHEATED. AS YOUR BODY CHANGES IN SHAPE YOU MAY NEED TO MODIFY YOUR EXERCISE TO ACCOMMODATE YOUR STRETCHED ABDOMINAL MUSCLES AND CHANGES YOU WILL EXPERIENCE IN YOUR SENSE OF BALANCE.

IF YOU DO NOT REGULARLY ENGAGE IN EXERCISE BUT WISH TO BEGIN DURING YOUR PREGNANCY YOU MAY TRY WALKING, SWIMMING, LOW IMPACT AEROBICS, OR EXERCISE VIDEOS INTENDED FOR USE IN PREGNANCY. REMEMBER TO MONITOR YOUR HEART RATE AND DO NOT OVERDO. IT IS ALSO IMPORTANT TO AVOID OVERHEATING IS A SAUNA OR HOT TUB DURING PREGNANCY.

WE HOPE THIS BROCHURE HAS ANSWERED SOME OF YOUR QUESTIONS AND HOPE YOU WILL CONTINUE TO REFER TO IT WHEN QUESTIONS ARISE DURING YOUR PREGNANCY.

NEW OBSTETRICAL HISTORY

Last Name:		First Name:	
Primary Provider/Group:		Provider Phone:	
Address:			

Birth Date:	Age:	Address:		
Marital Status:		Home Phone:	Office:	Cell:
Occupation:	Education: (Last Gr. Completed)	Insurance:		
Husband/Domestic Partner:			Phone:	Emergency Contact:
Father of Baby:			Phone:	Phone:

Total Pregnancies:	Full Term:	Premature:	Abortion Induced:
Abortion Spontaneous:	Ectopics:	Multiple Births:	Living:

MENSTRUAL HISTORY

LMP	<input type="checkbox"/> Definite	<input type="checkbox"/> Approximate (Month Known)	Menses Monthly <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency: days
	<input type="checkbox"/> Unknown	<input type="checkbox"/> Normal Amount/Duration	Prior Menses – Date:	Menarche: (age onset)
	<input type="checkbox"/> Final		On Birth Control at Concept: <input type="checkbox"/> Yes <input type="checkbox"/> No	

PAST PREGNANCIES (LAST SIX)

Date Month/Yr.	Gest. Wks.	Length of Labor	Birth Weight	Sex F/M	Type Delivery	Anes.	Place of Delivery	Pre Term Labor	Comments
				<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICAL HISTORY

	Detail Positive Remarks Include Date & Treatment		Detail Positive Remarks Include Date & Treatment
Diabetes	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	D(Rh) Sensitized	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
Hypertension	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	Pulmonary (TB, Asthma)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
Heart Disease	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	Seasonal Allergies	<input type="checkbox"/> Pos <input type="checkbox"/> Neg

Autoimmune Disorder	<input type="checkbox"/> Pos <input type="checkbox"/> Neg		Drug/Latex Allergies	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
Kidney Disease/UTI	<input type="checkbox"/> Pos <input type="checkbox"/> Neg		Reactions		
Neurologic/Epilepsy	<input type="checkbox"/> Pos <input type="checkbox"/> Neg		Breast	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
Psychiatric	<input type="checkbox"/> Pos <input type="checkbox"/> Neg		GYN Surgery	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
Depression/Postpartum Depression	<input type="checkbox"/> Pos <input type="checkbox"/> Neg		Oper./Hospitalizations (Yr./Reason)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
Hepatitis/Liver Disease	<input type="checkbox"/> Pos <input type="checkbox"/> Neg		Anesthetic Complications	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
Varicosities/Phlebitis	<input type="checkbox"/> Pos <input type="checkbox"/> Neg		History of Abnormal Pap	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
Thyroid Dysfunction	<input type="checkbox"/> Pos <input type="checkbox"/> Neg		Uterine Anomaly/Des	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
Trauma/Violence	<input type="checkbox"/> Pos <input type="checkbox"/> Neg		Infertility	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
History of Blood Transfus.	<input type="checkbox"/> Pos <input type="checkbox"/> Neg		Art Treatment	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
	Amt/Day Pre Preg	Amt/Day Preg	# Yrs Use	Relevant Family History	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
Tobacco				Other: []	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
Alcohol					
Illicit/Recreational Drugs					
Comments: []					
Symptoms Since LMP: []					

GENETIC SCREENING/TERATOLOGY COUNSELING					
Includes patient, baby's father, or anyone in either family with (blood relative to the baby only):					
	Yes	No		Yes	No
1. Patients age 35 yrs. or older as of estimated date of delivery.	<input type="checkbox"/>	<input type="checkbox"/>	13. Huntington's Chorea	<input type="checkbox"/>	<input type="checkbox"/>
2. Thalassemia (Italian, Greek, Mediterranean, or Asian background); MCV less than 80	<input type="checkbox"/>	<input type="checkbox"/>	14. Mental Retardation/Autism	<input type="checkbox"/>	<input type="checkbox"/>
3. Neural Tube Defect (Meningomyelocele, Spina bifida or Anencephaly)	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, Was Person Test for Fragile X?	<input type="checkbox"/>	<input type="checkbox"/>
4. Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	15. Other Inherited Genetic or Chromosomal Disorder	<input type="checkbox"/>	<input type="checkbox"/>
5. Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	16. Maternal Metabolic Disorder (eg., Type 1 Diabetes, PKU)	<input type="checkbox"/>	<input type="checkbox"/>
6. Tay-Sachs (Ashkenazi Jewish, Cajun, French Canadian)	<input type="checkbox"/>	<input type="checkbox"/>	17. Patient or baby's father has a child with birth defects not listed above	<input type="checkbox"/>	<input type="checkbox"/>
7. Canavan Disease (Ashkenazi Jewish)	<input type="checkbox"/>	<input type="checkbox"/>	18. Recurrent Pregnancy Loss or a Stillbirth	<input type="checkbox"/>	<input type="checkbox"/>
8. Familial Dysautonomia (Ashkenazi Jewish)	<input type="checkbox"/>	<input type="checkbox"/>	19. Medications (Including supplements, vitamins, herbs or OTC drugs, illicit/recreational drugs or alcohol since last menstrual period	<input type="checkbox"/>	<input type="checkbox"/>
9. Sickle Cell Disease or Trait (African)	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, Agent(s) and Strength/Dosage:[]		
10. Hemophilia or Other Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	20. Any Other:		
11. Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>			
12. Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>			
Comments/Counseling:					

INFECTION HISTORY					
	Yes	No		Yes	No
1. Live with someone with TB or exposed to TB	<input type="checkbox"/>	<input type="checkbox"/>	5. History of STD	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient or partner has history of genital herpes	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>
3. Rash or viral illness since last menstrual period	<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>
4. Hepatitis B, C	<input type="checkbox"/>	<input type="checkbox"/>	HPV	<input type="checkbox"/>	<input type="checkbox"/>

			HIV	<input type="checkbox"/>	<input type="checkbox"/>
			Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
			6. Other (see comments)	<input type="checkbox"/>	<input type="checkbox"/>

*****PATIENT INFORMATION FOR MEDICAL RECORDS*****

TODAYS DATE ___/___/___

Last Name _____ First Name _____ MI ___ Date of Birth ___/___/___ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

SSN _____ Marital Status M ___ S ___ W ___ D ___ Sep _____

Employer _____ Address _____

Person to notify in case of emergency _____ Phone _____

Family Dr _____ Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Fax _____ Pharmacy Address _____

SPOUSE, PARENT, OR GUARDIAN INFORMATION

Last Name _____ First Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Address _____

1ST INSURANCE COVERAGE

Insurance _____ Policy Holder _____ Relationship _____

Policy Holder SSN _____ Policy Holder Date of Birth ___/___/___

Effective Date ___/___/___

2ND INSURANCE COVERAGE

Insurance _____ Policy Holder _____ Relationship _____

Policy Holder SSN _____ Policy Holder Date of Birth ___/___/___

Effective Date ___/___/___

PLEASE SIGN AND RETURN TO RECEPTIONIST

I the undersigned, have insurance coverage with _____ and assign directly to Dr. Garland Scott all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, I hereby, authorize the doctor to release all information necessary to secure the payment of benefits.

DATE ___/___/___ SIGNED _____

**YOUR SIGNATURE IS NECESSARY FOR US TO
PROCESS ANY INSURANCE CLAIMS AND TO ENSURE
PAYMENT OF SERVICES RENDERED**

For Non-Medicare Patients

I hereby assign to the Provider any and all benefits from any insurance plans or any other protection maintained by the Patient and/or for the Patient's behalf or benefit and authorize and direct such benefits to be paid directly to the Provider for services provided to the Patient by the Provider. I certify that the information given by me to the Provider in applying for payment under Medicare and/or Medicaid programs, Insurance plans, or other protection is correct and complete. I authorize release of all records required to act on this release and assignment.

For Medicare Patients

I request that payment of authorized Medicare benefits be made to me or on my behalf to Garland Scott, M.D. for any services furnished me by that provider. I authorize any holder of my medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me to the Provider in applying for payment under the Medicare program is correct and complete. I authorize release of all records required to act on this release and assignment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

**I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE
READ THIS INFORMATION AND UNDERSTAND IT.**

Patient Name _____

Witness _____

Date _____

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Obstetrics and Gynecology



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To our patients:

Please notify the Medical Assistant of any special instructions that you may have for your **lab work**. As a general rule, most lab work is sent to Foote Hospital. If you or your insurance company require your lab work be sent to any other location, it is necessary to inform the Medical Assistant **PRIOR** to labs being sent out.

We are not responsible for labs being sent to the wrong location, if not specified at the time of service.

Patient Signature

Date

PRIVACY QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

2. Please print the telephone number, if any, where you want to receive calls about your appointments, lab and x-ray results, or other health care information.

() _____, this number is my: HOME WORK OTHER

3. Can confidential messages (i.e.: appointment & out pt service reminders) be left on your home phone answering machine or voicemail? YES NO

4. Can confidential messages (i.e.: appointment & out pt service reminders) be left with a family member that answers your home telephone? YES NO

If so who? _____

5. If you do not have voicemail, can a confidential message be left at your place of employment? YES NO

If yes, list number _____

PATIENT NAME _____

PATIENT/GUARDIAN SIGNATURE _____

DATE: _____ WITNESS _____

WOMENS ALLIANCE of JACKSON PRIVACY ACT

GARY FARHAT MD
GARLAND SCOTT MD

I have been given the HIPAA Privacy Statement to read and take with me to keep for reference.

I understand that Womens Alliance of Jackson, P.C. has notified me of their privacy policy.

I understand this document will be in my patient file.

I understand I will be notified of any changes to the Privacy Statement.

PATIENT'S NAME _____

SIGNATURE _____

DATE _____

* valid, unless revoked in writing.