Dear Patient,

It is a pleasure to welcome you to our practice of Women's Health and Midwifery. Thank you for choosing us to provide a program of comprehensive medical care for you. We believe that our primary responsibility is to provide our patients with the highest quality services, and we appreciate your confidence in selecting Genesis Birth Concepts.

Please complete the enclosed forms and bring them with you to your first appointment

DO NOT MAIL THE FORMS BACK TO OUR OFFICE

Please arrive 15 minutes prior to your appointment time in order to complete the check-in process. Make sure to bring your insurance card(s) and a photo identification card with you to your first appointment.

IN ADDITION, WE REQUEST THAT YOU DO NOT WEAR ANY LOTION OR STRONG PERFUME/ COLOGNE ON THE DAY OF YOUR APPOINTMENT, as this may affect the sensitivity to other patients.

Please feel free to contact us with any questions.

Kindest regards,
Lynette Allen-Pye, CNM
Chief Executive Officer
Genesis Birth Concepts Inc.
lynette@genesisbirthconcepts.com
404.291.8028

Genesis Birth Concepts, Inc.

Patient Financial Policy

Dear Patient,

PLEASE READ ALL INFORMATION AND SIGN WHERE INDICATED

- *You are responsible for paying all charges for services rendered to you at Genesis Birth Concepts Inc.* As a courtesy to you, we will gladly file a claim on your behalf to your insurance. carrier, and use all means to assure accurate and timely collection. If payment is not received from your insurance company in a reasonable period of time, we will look to you to pay any outstanding balances, while assisting you in further claims pursuit.

- We are contractually obligated with your insurance carrier to collect all applicable co-pays from our patients. *Please be prepared to pay this at each visit, or otherwise we will need to reschedule your appointment.*

- Our office will bill you for any amounts not covered by your insurance plan. Payment is expected upon receipt of that statement. In the event that you do not pay an outstanding balance in a reasonable amount of time, we will pursue collection activities, up to and including legal alternatives. You are responsible for all collection agency and legal fees incurred in our attempt to collect your delinquent account.

- IF YOUR INSURANCE REQUIRES A REFERRAL: You are responsible for making sure your visit has prior authorization by your primary care physician (PCP). If you arrive for a visit without the appropriate referral, you will either need to pay for your visit charges that day or reschedule your visit.

- SELF PAY PATIENTS: Payment is due upon services being rendered. Genesis Birth Concepts is pleased to offer several different health payment plan services such as Klarna and Care Credit. These two avenues require prior financial approval and are separate entities of Genesis Birth Concepts. To utilize either option, you must be pre-approved prior to your office visit. As the Patient, you are totally responsible for any and all financial responsibilities established with either entity. Please read any and all information regarding Klarna and/or Care Credit so that you will fully understand the expectations of each firm.

404.291.8028
GENESISBIRTHCONCEPTS.COM
2788 Bayard Street, East Point, Georgia 30344

Patient Financial Policy

Dear Patient,

PLEASE READ ALL INFORMATION AND SIGN WHERE INDICATED

- SELF PAY PATIENTS CONTINUED: Other financial assistance is offered for pregnant mothers through our Pregnancy Plans and even our Pelvic Floor Therapist, which offers session packages to patients prior to their visits and services rendered. Please read any and all information regarding pregnancy packages as well as other service packages, so that you are clear with the expectations per each plan.

- If you are seen for an annual exam, please let our provider know that you would like your visit filed under Preventive Coverage Guidelines. Our providers will make every effort to work with your insurance requirements, however, we will code your claim according to the services rendered and the diagnosis, as determined by your provider.

- If you need one of our providers to complete administrative forms, there will be a charge for their services. This fee is determined by the amount of the provider's time required and must be paid prior to completion of the form requested.

- We request at least 24 hours notification of cancellations. Chronic cancellations or no-shows will result in your being charged a missed appointment fee.

If you have any questions regarding our financial policy, please call BEFORE the provider sees you at 4040291.8028.

I acknowledge receipt and understanding of the above Financial Policy for Genesis Birth Center Inc.

____
Patient or Guardian Signature

____
Date

____
Printed Name of Patient

404.291.8028
GENESISBIRTHCONCEPTS.COM
2788 Bayard Street, East Point, Georgia 30344

GBC
Genesis Birth Concepts, Inc.

Patient Financial Policy

ANNUAL ROUTINE PHYSICAL EXAMINATION

A majority of insurance companies will pay 100% for a routine physical examination once per year. Depending on the insurance policy; blood work, chest x-ray, EKG, and spirometry may not be covered 100% and may be subject to your deductible and/ or coinsurance.

There has been frequent confusion regarding the difference between a Preventative Exam and a regular office visit. If an outgoing medical problem is in any way unstable or if a new problem is found, your insurance carrier may define this a s regular office visit and not part of your Preventive Coverage.

I UNDERSTAND THAT MY INSURANCE / MEDICARE MAY NOT PAY FOR THESE SERVICES AND WILL ACCEPT RESPONSIBILITY FOR PAYMENT.

______________________________ ______________________________

Patient or Guardian Signature Date

____

Printed Name of Patient

404.291.8028
GENESISBIRTHCONCEPTS.COM
2788 Bayard Street, East Point, Georgia 30344

Notice of Privacy Practices

Genesis Birth Concepts Inc.
2788 Bayard Street
Suite 100
East Point, Georgia 30344
Effective Date: June 20, 2024

Dear Patient,

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT THOROUGHLY.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

Information about you and your health is personal. We are committed to protecting your health information. We create a record of the care and services you receive at our practice, as well as records regarding payment for those services. We need these records to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our medical practice.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and our obligations regarding the use and disclosure of medical information.

HIPAA (Health Insurance Portability and Accountability Act) requires us to make sure that medical information which identifies you is kept private; and that we give you this notice of our privacy practices with respect to medical information about you.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. All of the way that we are permitted to use and disclose information will fall within one of the below categories.

FOR TREATMENT
We may use health information about you to provide you with the medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other personnel who are involved in taking care of you. Our practice also may share information about you in order to coordinate the different things you need, such as prescriptions and lab work.

FOR PAYMENT

We may use and disclose health information about you so the treatment and services you receive at our practice may be billed, and that payment may be collected from you, an insurance company, or another third party. We may need to disclose some of your health information about services your received at our practice so that your health plan will pay us for the services.

FOR HEALTH CARE OPERATIONS

We may use and disclose medical information about you for health care operations. Theses uses and disclosures are necessary to run our practice and make sure all patients receive quality care. For example. we may use medical information to review our treatment and services to evaluate the performance of our staff in caring for you.

We may use a sign-in sheet at the registration desk, and we may call you by name in the waiting room. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We will share your protected health information with business associates that perform various activities (e.g. billing, transcription services) for the practice. Whatever an arrangement between our office and a business associate involves the use and disclosure of your information, we will have a contract in place to protect your privacy.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE

We may release medical information about you to a family member or friend who is involved in your medical care. We may also give information to someone who help pay for your care. We may also tell your family and/or friends about your condition.

AS REQUIRED BY LAW

We will disclose medical information about you when required to do so by federal, state, or local law.

TO AVERT A SERIOUS THREAT TO HEALTH & SAFETY

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would be only to the appropriate authority or official able to prevent the threat.

RIGHT TO AN ACCOUNTING DISCLOSURE

This right applies to disclosures for purposes other than treatment, payment, or health care operations. To request this list or accounting of disclosures, you must submit your request in writing to the Practice Privacy Officer. Your request must state a time period, which may not include dates before June 20, 2024. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list.

RIGHT TO REQUEST RESTRICTIONS

You have a right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care purposes. You may also request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, you must make your request in writing to the Practice Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; (3) to whom you want the limits to apply.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION

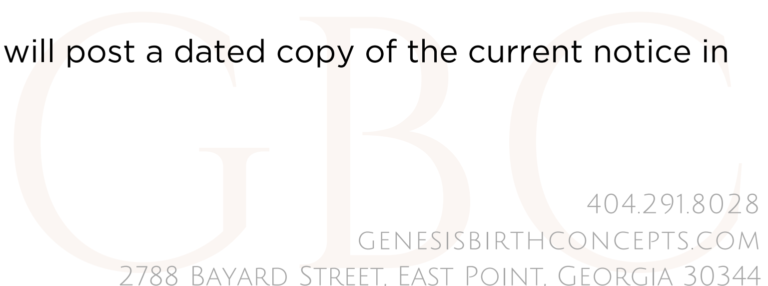
You may have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will accommodate all reasonable requests.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGE TO THIS NOTIVE

We reserve the right to change this notice. We will post a dated copy of the current notice in our practice.



NATIONAL SECURITY & INTELLIGENCE ACTIVITIES
We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law

INMATES
If you are an inmate of a correctional institution, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary to provide you with health care and to protect your health and safety of the health and safety of others.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

RIGHT TO INSPECT & COPY
You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records but does not include psychotherapy notes.

You must submit your request in writing to the Practice Privacy Officer, Vitoria Scruggs (victoria@genesisbirthconcepts or 404.291.8028). If you request a copy of the information, we may charge a fee for the costs of copying, mailing, and handling.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

RIGHT TO AMMEND
If you feel that the medica information that we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to the Practice Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not created by us or that which we deem accurate and complete.

Notice of Privacy Practices

Genesis Birth Concepts Inc.
2788 Bayard Street
Suite 100
East Point, Georgia 30344
Effective Date: June 20, 2024

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Victoria Scruggs, the Privacy Officer, at 404.291.8028 or victoria@genesisbirthconcepts.com. All complaints must be submitted in writing.

You will not be penalized in any way for filing a complaint.

OTHER USES OF MEDICAL RECORDS
Other uses and disclosures of medical information not covered by this notice will be made only with your written permission, which may be revoked in writing at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we have provided you.

Notice of Privacy Practices Acknowledgement

I understand my health information is private and confidential. Genesis Birth Concepts makes continuing efforts to protect the privacy and confidentiality of my personal health information.

I understand that GBC may use and disclose my personal health information to provide health care, to handle billing and payment, and to take care of other health care operations. (There will be no other disclosures of this information unless I specifically permit it. I understand that rarely the law may require the release of information without my permission.)

Genesis Birth Concepts has a detailed policy called the "Notices of Privacy Practices". It contains information about protecting my privacy. This "Notices of Privacy Practices" may be updated as needed and a copy will be available upon request. I will assist GBC by following office procedures (written request, reasonable time for completion and copying charges where indicated) If I choose to exercise any of my rights described in the "Notices of Privacy Practices". These rights include access, permission for release, records of disclosures, and communication by the available method of my choice.

My signature below indicates that I have read and may request a current copy of Genesis Birth Concept's "Notices of Privacy Practices".

______________________________	______________________________
Patient or Guardian Signature	Date
______________________________	______________________________
Printed Name of Patient	Relationship to Patient if Signed by Anyone Other Than the Patient

404.291.8028
genesisbirthconcepts.com
2788 Bayard Street, East Point, Georgia 30344

Patient Appointment Policy

APPOINTMENTS:

If you are unable to keep your appointment, you must give us at least 24 hours' notice. Not doing so will result in a **$35.00 missed appointment fee.** If you fail to notify us on a continuous basis, you may be discharged from the practice.

LATE PATIENTS

If you arrive more than 20 minutes past your scheduled appointment time, we may ask you to reschedule. If our schedule allows, we will reschedule you within the same day. If not, we will reschedule you for the earliest available open.

I have read and understood the above policies and agree to abide by these policies, I hereby acknowledge that I am responsible for keeping my scheduled appointments and have been informed of the policy of Genesis Birth Concepts Inc. This charge, if incurred, cannot be billed to my insurance company.

______________________________ ______________________________

Patient or Guardian Signature Date

____

Printed Name of Patient

404.291.8028
GENESISBIRTHCONCEPTS.COM
2788 Bayard Street, East Point, Georgia 30344

GBC
Genesis Birth Concepts, Inc.

Form Completion Policy

If you need a form completed by your provider, below you will find the cost associated with each type of form.

Family Medical Leave Act (FMLA) Paperwork:
    $25 for a single page up to $50 maximum

Disability Paperwork:
    $25.00 for employer information requests, provider statements and/ or disability insurance requests

Attorney's Paperwork:
    $50 minimum for letter or reports sent on your behalf

Itemized Statements:
    $10 for every statement after 1st request (1st statement at no charge)

Miscellaneous Paperwork (supplies etc.)
    $25 minimum per page (at provider's discretion)

Patient must be current on their account before any forms will be completed.

_______________________________ _______________________________
Patient or Guardian Signature Date

____
Printed Name of Patient

404.291.8028
genesisbirthconcepts.com
2788 Bayard Street, East Point, Georgia 30344

Telehealth Consent Form

Patient Name ____ DOB __________________

Provider Name _______________________________________

I hereby consent to receive healthcare services through telemedicine or telehealth platforms provided by Genesis Birth Concepts Inc. I understand telehealth services may involve video conferencing, audio, and/ other electronic communication to connect me with my healthcare.

I understand that regular office visit copayments and coinsurance will apply for telehealth. I understand that copayments will need to be collected prior to the telehealth appointment.

I understand that my healthcare provider will make every effort to ensure the security and privacy of my personal and medical information. However, I acknowledge that there are risks associated with electronic communication and that my information could be interpreted or disclosed without my consent.

I understand that my healthcare provider will document my telehealth visit and that my medical records will be maintained in accordance with the state and federal regulations

By signing below, I acknowledge that I have read and understand the information provided in this Telehealth Consent Form and consent to receive healthcare services through telehealth platforms.

________________________________   ________________________________

Patient or Guardian Signature   Date

____

Printed Name of Patient

404.291.8028
genesisbirthconcepts.com
2788 Bayard Street, East Point, Georgia 30344

Patient Waiver for Covered & Non-Covered Services

Patient Name ____ DOB __________________

Provider Name _______________________________________

Due to the healthcare changes, your insurance may not pay for all of your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your provider believes that certain procedures and/or tests performed are an important part of your medical care and recommends that you receive these services as part of your current treatment plan, although they may be covered but not at 100% by your health insurance.

However, in cases that the services were rendered are not considered to be medically necessary benefit under your health insurance, should you choose to receive these services; you will be personally responsible for the payment of such services.

I acknowledge that I have been informed in advance before receiving services, that some services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

________________________________ ________________________________
Patient or Guardian Signature Date

____
Printed Name of Patient

This form must be signed by the patient or legal guardian PRIOR to receiving any services or items and must be maintained in the patient's medical record

404.291.8028
genesisbirthconcepts.com
2788 Bayard Street, East Point, Georgia 30344

Consent For Release of Information

I Hereby Authorize:

____

To Release Information From The Medical Record Of:

____
Patient's Full Name

____
Patient's Date of Birth

To: Genesis Birth Concepts Inc.
2788 Bayard Street
Suite 100
East Point, Georgia 30344
Phone: 404.291.8028
Fax: 404.748.4942
Website/ Patient Portal: Genesisbirthconcepts.com

Attention: _____________________________
Provider's Name

This is information to be released for the purpose of:

____

____

__________________________ ______________________
Patient's Signature Date

New Patient Registration Form

Patient Information   Date ______________

Last Name ______________________ First Name ______________________

Middle Initial _____ Date of Birth ______________ Gender ______________

Street Address ______________________ Apt/Ste# ______________

City ______________ State ______________ Zip Code ______________

Phone Number ______________________ Work Number ______________________

Email Address ____

Social Security Number ______________________ Language ______________

Race: American Indian/ Alaskan Native ____ Asian ____ Black/African American ____

Native Hawaiian/ Other Pacific Islander ____ White/ Caucasian ____ Other ____

Ethnicity: Hispanic/ Latino ____ Non-Hispanic/ Latino ____

Referring Physician/ Facility ____

Emergency Contact Name ______________________ Relationship ______________

Emergency Contact Phone Number ______________________

Marital Status: Single ____ Married ____ Divorced ____ Separated ____

Widowed ____ In a Relationship ____

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Patient Signature ______________________

New Patient Registration Form

Patient Insurance Information   Date ____________

Last Name ______________________ First Name ______________________

Are You Covered by Insurance? Yes ______ No ______

Primary Insurance ______________________ Policy Number ____________

Subscriber's Name ______________________ Policy Group Number ____________

Subscriber's Social Security Number ______________ Relationship ____________

Subscriber's Date of Birth ______________ Insurance Co-Pay ____________

Secondary Insurance Name ______________________ Policy Number ____________

Subscriber's Name ______________________ Policy Group Number ____________

Subscriber's Social Security Number ______________ Relationship ____________

Subscriber's Date of Birth ______________ Insurance Co-Pay ____________

Disclaimer: The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Genesis Birth Concepts Inc. to release any information required to process my claims.

Patient Signature ______________________ Date ____________

404.291.8028
genesisbirthconcepts.com
2788 Bayard Street, East Point, Georgia 30344

GENESIS BIRTH CONCEPTS, INC.

Patient Social History

DATE ____________

Last Name ____________ First Name ____________

Place of Birth ____________ Occupation ____________

Marital Status (Duration/ Number of Marriages ____________
Number

Number of Children/ Ages ____________

Highest Level of Education ____________ Pets/Animals ____________

Hazardous Exposures At Work/ Home ____________

Travel Outside of U.S. In Past 5 Years ____________

Tobacco Usage (Current/Past) ______ Amount/ Duration ______ Date of Cessation ______

Caffeine Usage ____________ How much per day? ____________

Alcohol Usage ____________ How much per week? ____________

Immunizations (In past 10 years, please indicate date of last shot)

Measles/MMR	
Tetanus/ DPT/DT	
Hepatitis	
Flu	
Pneumonia	
Covid	
RSV	

HPV	
MenB	
Chickenpox	
Shingles	

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GENESISBIRTHCONCEPTS.COM
2788 BAYARD STREET, EAST POINT, GEORGIA 30344

GBC

GENESIS BIRTH CONCEPTS, INC.

Patient Symptom Review

DATE ____________

Last Name ____________ First Name ____________

Please check the box next to the symptoms which you are currently experiencing.

General	
Fever	☐
Fatigue	☐
Weight Change >10 lbs.	☐
Difficulty Sleeping	☐
Mumps	☐
Measles	☐
HIV Infection	☐
Blood Transfusion	☐
Breast Implants	☐
Alcoholism	☐
Chills	☐
Sweats	☐
Appetite Change	☐
Anemia	☐
Excessive Daytime Sleepiness	☐

Pulmonary	
Cough	☐
Coughin Up Blood	☐
Coughin Up Mucous	☐
Bronchitis	☐
Pnuemonia	☐
Pleurisy	☐
Wheezing	☐
Asthma	☐
Positive TB Skin Test	☐
Tuberculosis	☐
Previous Chest X-Ray	Date ____________

Skin	
Color/ Texture Change	☐
Hair/ Nail Change	☐
Rashes	☐
Itching	☐
Easily Bruised	☐
Hives	☐
Frequent Skin Infections	☐
Eczema	☐
Psoriasis	☐
Skin Cancer	☐

Cardiovascular	
Palpitations	☐
High Blood Pressure	☐
Chest Pain	☐
Heart Disease	☐
Heart Murmur	☐
Mitral Valve Prolapsed	☐
Shortness of Breath	☐
Swelling	☐
Blue Fingers or Toes	☐
Phlebitis/ Blood Clots	☐
Leg Pain When Walking	☐
Previous EKG	☐
Previous Treadmill Test	Date ____________
Rhuematic Fever	Date ____________
Pacemaker	☐
Passing Out	☐

Eyes/ Ears/ Nose/ Throat	
Sinusitis	☐
Change in Vision	☐
Color Blindness	☐
Night Blindness	☐
Blurred Vision	☐
Double Vision	☐
Peripheral Vision Change	☐
Ear Pain/ Ache	☐
Difficulty Hearing	☐
Noises In Ears	☐
Previous Eye Exam	Date ____________
Previous Dental Exam	Date ____________
Hay Fever/ Allergies	☐
Dizziness/ Vertigo	☐
Snoring	☐

GENESIS BIRTH CONCEPTS, INC.

Patient Symptom Review

DATE ____________

Last Name ____________ First Name ____________

Please check the box next to the symptoms which you are currently experiencing.

Gastrointestinal	
Food Intolerance	☐
Problems w/ Teeth or Gums	☐
Abnormal Taste	☐
Sore Tongue	☐
Trouble Swallowing	☐
Heartburn	☐
Stomach Pain	☐
Excessive Belching	☐
Bloating	☐
Nausea	☐
Vomiting	☐
Vomiting Blood	☐
Ulcers	☐
Hepatitis/ Jaundice	☐
Gallbladder Disease	☐
Hemorrhoids	☐
Pancreatitis	☐
Inflammatory Bowel	☐
Spastic Colon	☐
Change In Stool	☐
Black Stool	☐
Blood In Stool	☐
Diarrhea	☐
Constipation	☐
Excessive Gas	☐
Lactose Intolerance	☐
Reflux	☐
Hiatal Hernia	☐
Colonoscopy	Date ____________
Endoscopy	Date ____________

Endocrine	
Ring Size Change	☐
Shoe Size Change	☐
Abnormal Sweating	☐
Change In Appetite	☐
Breast Milk	☐
Head/Neck Irradiation	☐
Thyroid Disease	☐
Goiter/ Enlarged Thyroid	☐
Cold Intolerance	☐
Heat Intolerance	☐
Trouble Losing Weight	☐
Excessive Hair Growth	☐
Loss Of Hair	☐
Acne	☐
Breast Enlargement	☐
Excessive Hunger	☐
Excessive Thirst	☐
Excessive Urination	☐
Sugar In The Urine	☐
Diabetes	☐
High Blood Calcium	☐
Low Blood Calcium	☐
Osteoporosis	☐
Gestational Diabetes	☐

GENESIS BIRTH CONCEPTS, INC.

Patient Symptom Review

DATE ______________

Last Name ______________________ First Name ______________________

Please check the box next to the symptoms which you are currently experiencing.

Reproductive	
Age You First Started Your Period	_______
Last Menstrual Cycle	Date ___________
How Many Pregnancies Have You Had? (Include Successful & Unsuccessful)	_______
How Many Pregnancies Went To Term?	_______
Weight of Newborns?	___________
How Many Pregnancies Were Premature?	_______
How Many Miscarriages/ Abortion Have You Had	_______
Any Complications w. Pregnancy?	_______
Have You Had A Hysterectomy (Include Date)?	Date ___________
Were Your Ovaries Removed?	_______
Last Pap Smear Test?	Date ___________
Last Mammogram Test?	Date ___________
Change In Your Periods	☐
Hot Flashes/ Flushes	☐
Sweats	☐
Vaginal Dryness	☐
Vaginal Infections	☐
PMS	☐
Pain w. Sexual Intercourse	☐
Infertility	☐
Change in Sexual Desire	☐
Sexually Transmitted Disease	☐
Breast Lumps	☐
Breast Pain	☐
Breast Discharge	☐
Breast Cancer	☐
Wetting of Pants/ Incontinence	☐

GBC GENESIS BIRTH CONCEPTS, INC.

Patient Symptom Review

DATE ______________

Last Name ______________________ First Name ______________________

Please check the box next to the symptoms which you are currently experiencing.

Neurological	
Weakness	☐
Stroke	☐
Paralysis	☐
Difficulty Speaking	☐
Seizures	☐
Headaches	☐
Change In Sensation	☐
Numbness/ Tingling	☐
Feeling Faint	☐
Change In Handwriting	☐
Tremor	☐
Anxiety	☐
Phobias	☐
Hallucinations	☐
Depression	☐
Psychiatric Treatment	☐
Suicidal Ideation	☐
Suicide Attempt	☐
Physical Abuse	☐
Sexual Abuse	☐
Verbal Abuse	☐
Sex Trafficked	☐
Memory Loss	☐

Musculoskeletal	
Pain in Muscles/ Joints	☐
Joint Swelling	☐
Muscle Cramps	☐
Arthritis	☐
Joint Stiffness	☐
Back Pain	☐
Handicapped	☐
Gout	☐
Bone Density Test	Date ________

Urinary	
Excessive Urination	☐
Urination at Night	☐
Painful Urination	☐
Urge to Urinate	☐
Urinary Tract Infection	☐
Kidney Stones	☐
Urine Leakage	☐
Change in Urine Stream	☐
Trouble Starting Unrination	☐
Blood In Urine	☐
Brown Urine	☐

404.291.8028
GENESISBIRTHCONCEPTS.COM
2788 BAYARD STREET, EAST POINT, GEORGIA 30344

GENESIS BIRTH CONCEPTS, INC.

Medical History Questionnaire

DATE ______________

Last Name ______________________ First Name ______________________

Date of Birth ______________

Medications: Please list all of your medications, including over the counter, vitamins, and food supplements. (If there is not enough room, please use available space on the back of this page.)

Medication	Dosage	Frequency

GBC

Genesis Birth Concepts, Inc.

Medical History Questionnaire

Date ______________

Last Name ______________________ First Name ______________________

Date of Birth ______________

Family History: Do any of your close relatives/ immediate family have the following conditions?

Condition	Yes/ No	Relatives
Heart Disease		
High Blood Pressure		
Stroke		
High Cholesterol		
Diabetes		
Thyroid Disease		
Kidney Stones		
Osteoporosis		
Mental Illness		
Bleeding Disorder		
Anemia		

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genesisbirthconcepts.com
2788 Bayard Street, East Point, Georgia 30344

GBC

Genesis Birth Concepts, Inc.

Medical History Questionnaire

Date ______________

Last Name ____________________ First Name ____________________

Date of Birth ______________

List All Hospitalizations, Surgeries, Accidents/ Injuries: If there is not enough room, please use available space on the back of this page.

Date	Diagnosis	Location

Allergies	Response

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