Welcome to Harnett OB/GYN

Thank you for choosing Harnett Obstetrics for your health and wellness needs. As an Obstetrics and Gynecology practice, we welcome patients from ages 16 and up. Patients under the age of 16 can be seen at the provider’s discretion. Our approach to patient care is personal and caring. You will find that our office is relaxed and friendly, with qualified and caring professionals here to meet your needs. Our providers are:

Michael Zich, MD       Ogochukwu Okpala, MD

We are here for you and hope to accommodate your appointments as needed. If you are sick, please contact our office immediately. We will make every effort to schedule an appointment for you the same day. However, keep in mind there may be a wait in the office if we have to work you in. Harnett Health System is a teaching facility; therefore, lending an opportunity to be seen by Campbell Residents who provide quality medical care and also aid in ease of making appointments either same or next day.

Harnett OB/GYN is currently accepting all insurance plans and will gladly file insurance on your behalf. We provide a discount for prompt payment to patients paying in cash as self-pay.

Please have with you at the first appointment:

✔ All medications
✔ Immunization Records
✔ Picture ID
✔ Insurance Cards
✔ Name/Address/telephone number of previous provider (if applicable)

Please finish all paperwork before your appointment time!

• Be sure to bring all medications to every appointment, as well as a list of any concerns you would like to talk about with your provider.

• PRESCRIPTIONS AND REFILLS
  Planning ahead is very beneficial in the area of prescription and refills. We encourage you to be aware of refill and expiration dates of your medications in order to avoid any lapse or delay. For refills, we ask that you obtain them at the time of service. Otherwise all other refill request must go through your pharmacy. Please allow 24 hours prior to requesting a prescription refill request. Unfortunately no prescription refills will be called in after hours or on the weekends.

• If you need any special accommodations for a disability, please inform us so we can better meet your needs. If there is any way we can improve your experience, please let us know. Your feedback is important to us.
We ask you to be on time for your appointments, if you are late for your appointment please call ahead. However understand that you may have to be rescheduled.

HARNETT HEALTH
Physician Office Practices

PATIENT INFORMATION:

Last Name: _________________________  First Name: _______________________  Middle: _____________
Date of Birth: _____________________ Social Security Number: _______________________________
Address: ____________________________ City: __________________
State ________ Zip Code: __________
Home Phone Number: _______________  Cell Number: __________________________
Emergency Contact: __________________ Phone Number: ______________________
Relation: ____________________________
Email Address: __________________________
Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ Pi/Hawaii ☐ American/Indian ☐ Pt Decline ☐ Other
Sex: ☐ Male ☐ Female
Language: ☐ English ☐ Spanish ☐ Other: __________________________

RESPONSIBLE PARTY INFORMATION: (If not above)

Last Name: __________________________ First Name: __________________________ Middle: ___________
Date of Birth: _____________________ Social Security Number: _______________________________
Email: ____________________________
Address: __________________________ City: __________________
State ________ Zip Code: __________
Employer: __________________________ Occupation: __________________________
Work Phone Number: __________________________
Employer Address: __________________________ City: __________________
State ________ Zip Code: __________
Home Phone Number: __________________________ Cell Number: __________________________
Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ Pi/Hawaii ☐ American/Indian ☐ Pt Decline ☐ Other
Sex: ☐ Male ☐ Female
Language: ☐ English ☐ Spanish ☐ Other: __________________________
Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other __________________________

Patients Relationship to Responsible Party: ☐ Self-18 ☐ Child

Is this visit related to:
☐ Industrial  Were You Injured on The Job? ☐ Yes ☐ No  Date of Injury: _________________
Industrial Claim #: _________________
☐ Accident  Was an Automobile Involved? ☐ Yes ☐ No  Date of Accident: _________________
Attorney Name: __________________________
☐ Other ☐ Yes ☐ No  Date of Accident: _________________ Attorney Name: __________________________

PHARMACY:

Name: ____________________________ Address: __________________________
City: ____________________________ State: __________ Zip Code: __________________________
Phone number: __________________________
INSURANCE INFORMATION:

Primary Insurance Company: _________________________________
Policy #: _______________ Group #: _______________
Subscriber’s Name: ________________________________  Subscribers date of birth: ____________________
Subscriber’s Address: __________________________________ City: ________________
State: _______________ Zip Code: _______________
Subscriber’s Social Security Number: ______________________________
Subscriber’s Sex: ☐ Male ☐ Female
Subscriber’s Relationship to Responsible Party: ☐ Self-1 ☐ Spouse-2 ☐ Other-0

Secondary Insurance Company: _________________________________
Policy #: _______________ Group #: _______________
Subscriber’s Name: ________________________________  Subscribers date of birth: ____________________
Subscriber’s Address: __________________________________ City: ________________
State: _______________ Zip Code: _______________
Subscriber’s Social Security Number: ______________________________
Subscriber’s Sex: ☐ Male ☐ Female
Subscriber’s Relationship to Responsible Party: ☐ Self-1 ☐ Spouse-2 ☐ Other-0

Tertiary (Third) Insurance Company: _________________________________
Policy #: _______________ Group #: _______________
Subscriber’s Name: ________________________________  Subscribers date of birth: ____________________
Subscriber’s Address: __________________________________ City: ________________
State: _______________ Zip Code: _______________
Subscriber’s Social Security Number: ______________________________
Subscriber’s Sex: ☐ Male ☐ Female
Subscriber’s Relationship to Responsible Party: ☐ Self-1 ☐ Spouse-2 ☐ Other-0

I, __________________________________________________________, certify that the completed information is correct and I received the Notice of Privacy Practice Form on ____/____/____.
NO SHOW POLICY

A pattern of repeated “no shows” for appointments will result in dismissal from the practice. A “no show” is defined as a missed appointment in which the individual does not call to cancel or reschedule the appointment time.

Your signature below indicates that you are aware and understand this policy. Should you have any questions, please direct them to the front office representative.

______________________________  __________________________
Signature of patient, if minor, signature of responsible party  Date
Financial Agreements and Authorization for Treatment: I hereby authorize Harnett Health Medical Services and its physicians and such assistants as a physician may designate to furnish and perform on me or the patient stated above ("Patient") such medical care, examination, and treatment as may be ordered by a Harnett Health Medical Services physician in his or her medical judgment and such medical care, examination, or treatment as is reasonable incident thereto. I hereby authorize direct payment to Harnett Health Medical Services of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by Harnett Health Medical Services to the Patient. I understand that, to the extent permitted by applicable law, I am and I agree hereby to be, financially responsible to Harnett Health Medical Services for charges not covered by this agreement, and I hereby guarantee payment to Harnett Health Medical Services on demand for all such charges. I understand that all co-pays and self-pay monies are collected up front before services are rendered.

Signature _______________________________ Date ____________

Please check one:  [ ] Patient    [ ] Guarantor   [ ] Authorized Representative   [ ] Parent or Guardian of Minor

Authorization to Release Information: I hereby authorize Harnett Health Medical Services to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient’s examination and/or treatment to any insurance company, government agencies and their agents, and professional review organizations with which I or the Patient stated above may have insurance coverage or which may be assisting in payment of the medical care provided by Harnett Health Medical Services to me or the Patient stated above. I also hereby authorize Harnett Health Medical Services to release any medical information to any licensed physician, health care provider, or medical facility to which I or the Patient stated above may be referred, admitted, or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action already has been taken.

Signature _______________________________ Date ____________

Please check one:  [ ] Patient    [ ] Guarantor   [ ] Authorized Representative   [ ] Parent or Guardian of Minor

Receipt of Notice of Privacy Practices: I understand and have been provided with a Harnett Health Medical Services’ Notice of Privacy Practices, which provides a more complete description of how Patient health information may be used or disclosed. I understand that Harnett Health Medical Services reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from any employee of Harnett Health Medical Services.

Signature _______________________________ Date ____________

Please check one:  [ ] Patient    [ ] Guarantor   [ ] Authorized Representative   [ ] Parent or Guardian of Minor
HARNETT HEALTH
Physician Office Practices
Patient Questionnaire

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

Name: ______________________________________________ Relationship: __________________________
Name: ______________________________________________ Relationship: __________________________

2. Please list the family members or significant others, if any, whom we may inform about your medical condition

ONLY IN AN EMERGENCY:
Name: _______________________________ Relationship: ____________ Phone Number: _______________
Name: _______________________________ Relationship: ____________ Phone Number: _______________

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

___________________________________________________________________________________________________________________

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked “CONFIDENTIAL”. ☐ YES ☐ NO

5. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number: ___________________________

“I am fully aware that a cell phone is not a secure and private line.”

6. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?

☐ YES ☐ NO (If no, you will not receive an appointment reminder.)

7. Would you like to participate in the activation of FollowMyHealth? ☐ Yes ☐ No

Using FollowMyHealth, you can:
● Communicate with your care team
● Access your test results
● View your recent clinic visits
● Request Prescription Renewals
● And more…..

To join please provide your email where your activation code will be sent:

___________________________________________________________________________________________________________________

8. I have been given a copy of my Patient Rights and Responsibilities. ☐ YES ☐ NO

9. I have been given a copy of the Joint Notice of Privacy Practices. ☐ YES ☐ NO

10. Advance Directives: Please check appropriate box.

   Health Care Power of Attorney  ☐ YES ☐ NO
   ☐ YES ☐ NO

   Living Will  ☐ YES ☐ NO
   ☐ YES ☐ NO

   Have you supplied us with a copy

Patient/Legal Representative Signature: ______________________________ Date: __________ Time: __________
Medical History and Questionnaire

Primary Care Provider: ______________________________

Medications (Include vitamins, herbs, and anything OTC):

Name: ______________________________ Dose: ____________ Frequency: ________________
Name: ______________________________ Dose: ____________ Frequency: ________________
Name: ______________________________ Dose: ____________ Frequency: ________________
Name: ______________________________ Dose: ____________ Frequency: ________________
Name: ______________________________ Dose: ____________ Frequency: ________________
Name: ______________________________ Dose: ____________ Frequency: ________________

Allergies:

Allergen: ______________________________ Reaction: _________________________________________
Allergen: ______________________________ Reaction: _________________________________________
Allergen: ______________________________ Reaction: _________________________________________
Allergen: ______________________________ Reaction: _________________________________________
Allergen: ______________________________ Reaction: _________________________________________

Menstrual Cycle:

Age of onset of menstrual cycle: _________________ First day of last menstrual cycle: _________________
If post-menopausal, date of your last cycle: ________________________

Procedures:

Date of last PAP smear: ____________________ Have you ever had an abnormal pap? Yes ☐ No ☐
Date of last mammogram: __________________ Have you ever had an abnormal mammogram? Yes ☐ No ☐
Date of last colonoscopy: __________________

Pregnancies:

(Please check one of these for Pregnancy Type)

<table>
<thead>
<tr>
<th>Day/Month/Year of delivery or miscarriage</th>
<th>Vaginal</th>
<th>Cesarean</th>
<th>Abortion</th>
<th>Miscarriage</th>
<th>Ectopic</th>
<th>Preterm (Yes or no)</th>
<th>Live born (Yes or no)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sexually Transmitted Diseases:

Have you ever had . . . ?

Chlamydia: Yes ☐ No ☐  Gonorrhea: Yes ☐ No ☐
Syphilis: Yes ☐ No ☐  HIV: Yes ☐ No ☐
Genital Warts: Yes ☐ No ☐  Genital Herpes: Yes ☐ No ☐
# Self & Family History

Please check the box if you or a family member have had any of these diseases.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Self</th>
<th>Mother</th>
<th>Father</th>
<th>Sister</th>
<th>Brother</th>
<th>Grandparent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood clots in arm or leg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with stopping bleeding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High cholesterol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colon Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uterine Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ovarian Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please explain in space provided</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>