

PARKWEST GYNECOLOGY, P.C.

9330 Parkwest Blvd., Suite 302 Knoxville, TN 37923
(865) 531-5878

PATIENT REGISTRATION FORM

Please complete form using your legal name as it appears on your social security card.

Date: _____ Email Address: _____ Cell #: (____) _____

Patient's Name: _____ Date of Birth: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed SSN: _____

Street Address: _____ Apt# _____ Phone: _____

City: _____ State: _____ Zip: _____

Employment Status: Full-Time Part-Time Retired Unemployed Disabled Self Employed

Employer Name: _____ Phone: (____) _____

Street Address: _____ City: _____ State: ___ Zip: _____

Husband's Name: _____ Date of Birth: _____

Husband's SSN: _____ Husband's Employer: _____ Phone: (____) _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____

Family Physician: _____ Referred By: Physician Friend Other

Insurance: Please allow us to make a copy of your insurance card(s) and provide us with all pertinent information regarding your insurance coverage.

Primary insurance Company: _____ Group #: _____

Insured's Name: _____ ID #: _____

Insured's Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance Company: _____ Group #: _____

Insured's Name: _____ ID #: _____

Insured's Date of Birth: _____ Relationship to Patient: _____

If it is necessary for me to bring my child at the time of my visit, I understand that it is my responsibility to watch out for the safety and well being of my child.

Patient's Signature: _____ Date: _____

Patient History and Medical Information

Date: _____ Patient Phone # _____

Patient Name: _____ Occupation: _____

Marital Status: Married, Single, Separated, Divorced, Widowed

Any recent hospitalizations?: _____

Allergies:	Chronic Illnesses:	Surgeries:
None Known: <input type="checkbox"/>		

Medications:

Name of Medication	Dosage	Taken how often	Physician who prescribed	Medical Problem

Date of last pap smear: _____ Date of last mammogram: _____

Have you ever had an abnormal pap smear? Y N How long ago? _____

Do you perform self breast exams? Monthly Sometimes Never

Sexually Active: Y N Method of birth control: _____

If over age 50, have you had :

a sigmoidoscopy or colonoscopy in past 5 years? Y N
a bone density test (test for osteoporosis)? Y N

Important Information Regarding Preventive and Screening Services

We are pleased that you have chosen our office today for your annual gynecological (GYN) exam. Early detection and prevention of possible health problems is an important part of taking care of yourself.

Please understand that your annual GYN exam is preventive in nature and we are required by law to submit our bill to your insurance company using accurate information about the type of service you received. In addition, your doctor may order screening tests during your annual GYN exam. These tests may include a Pap smear, urine testing, blood testing, or stool screening.

Insurance companies vary in their coverage for preventive and screening services. We want you to be aware that the cost of your preventive and screening services may be your responsibility if they are not covered by your insurance carrier. If a medical problem is discovered during your preventive medicine visit, we will bill your insurance company for additional services according to regulations governing insurance billing and our contract with your insurance company.

Thank you for choosing us to assist you with your healthcare needs. If you have any questions or concerns about this information, please do not hesitate to ask our front office for more information.

I have read the above information and understand that I may receive preventive and screening services that will not be covered by my insurance plan. I agree to pay promptly for any non-covered services.

Signature of Patient or Guarantor

Date