

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: _____

PARKWEST GYNECOLOGY, P.C.

Patient Information and History

Name: _____ Date: _____

Age of your first period: ____ Cycle length in days: ____ How many days does your period last? _____

If using birth control, which method? Birth control pills Foam Condoms IUD Depo-provera
 Diaphragm Tubal Ligation Vasectomy Withdrawal

Have you ever had an abnormal Pap smear? No Yes, Date: _____ Treatment _____

Do you do self breast exam? Never Sometimes Monthly Date of last mammogram: _____

If age 50 or older, have you had:

A sigmoidoscopy or colonoscopy in the past five years? Yes No

A bone density test (test for osteoporosis)? Yes No

Operations/Hospitalizations

Operation/Hospitalization	Date	Name of Hospital/Doctor

Obstetric History

		Number			Number			Number
Pregnancies:			Live Births:			Miscarriages:		
Living Children:			Premature:			Abortions:		
No.	Birth date	Birth Weight	Baby's Sex	Weeks Pregnant	Type of Delivery	Complications?		
1								
2								
3								
4								
5								
6								

Personal Past History of Illness

Major Illness	Yes	No	Major Illness	Yes	No	Major Illness	Yes	No
Asthma			Stroke			Blood transfusions		
Kidney Stones			Rheumatic Fever			Seizures / Epilepsy		
Kidney Infection			Blood clots lungs/legs			Bowel problems		
Tuberculosis			Eating disorder			IBS/Spastic colon		
STD's			Lupus			Hepatitis/liver disease		
HIV/AIDS			Cancer			Thyroid disease		
Heart trouble			Ulcer, reflux, hernia			Gallbladder problems		
Diabetes			Depression/anxiety					
High blood pressure			Anemia					

PARKWEST GYNECOLOGY, P.C. PATIENT INFORMATION & HISTORY

Name: _____ Date: _____

Current Medications

(including hormones, vitamins, herbs, non-prescription and diet medications)

Drug Name	Dosage	Medical Problem	Drug Name	Dosage	Medical Problem

Drug Allergies

Check Here If No Known Drug Allergies

Drug	What happens when you take it?

Review of Systems Mark (x) all that apply

<p>1. Constitutional</p> <p><input type="checkbox"/> Recent weight loss/gain</p> <p><input type="checkbox"/> Fatigue</p>	<p>5. Genitourinary</p> <p><input type="checkbox"/> Abnormal bleeding</p> <p><input type="checkbox"/> Painful Periods</p> <p><input type="checkbox"/> Painful intercourse</p> <p><input type="checkbox"/> Abnormal vaginal discharge</p> <p><input type="checkbox"/> Difficulty becoming pregnant</p> <p><input type="checkbox"/> PMS</p> <p><input type="checkbox"/> DES exposure</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Pain with urination</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Involuntary loss of urine</p> <p><input type="checkbox"/> Pelvic pain</p>	<p>7. Neurologic</p> <p><input type="checkbox"/> Dizziness or light-headedness</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Frequent or severe headaches</p>
<p>2. Ears, Nose, Throat</p> <p><input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> Mouth sores</p>	<p>6a. Skin</p> <p><input type="checkbox"/> Unwanted hair</p> <p><input type="checkbox"/> Black or enlarged moles</p> <p><input type="checkbox"/> Rash or itching</p>	<p>8. Psychiatric</p> <p><input type="checkbox"/> Depression or crying episodes</p> <p><input type="checkbox"/> Sleep problems</p> <p><input type="checkbox"/> Panic attacks/anxiety</p>
<p>3. Cardiovascular</p> <p><input type="checkbox"/> Swelling of feet or legs</p> <p><input type="checkbox"/> Rapid or irregular heart beat</p> <p><input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> Varicose veins</p>	<p>6b. Breasts</p> <p><input type="checkbox"/> Pain in breasts</p> <p><input type="checkbox"/> Nipple discharge</p> <p><input type="checkbox"/> Lumps</p>	<p>9. Endocrine</p> <p><input type="checkbox"/> Glandular / Hormone problems</p> <p><input type="checkbox"/> Hair loss</p> <p><input type="checkbox"/> Abnormal thirst or urination</p> <p><input type="checkbox"/> Hot flashes</p>
<p>4. Gastrointestinal</p> <p><input type="checkbox"/> Frequent diarrhea</p> <p><input type="checkbox"/> Bloody stool/rectal bleeding</p> <p><input type="checkbox"/> Nausea/vomiting</p> <p><input type="checkbox"/> Constipation</p>		<p>10. Lymphatic</p> <p><input type="checkbox"/> Enlarged lymph nodes</p>

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Patient Information and History

Patient Name: _____ Date: _____

Family History

Major Illness	Yes	No	Physician Notes	Major Illness	Yes	No	Physician Notes
Heart disease				Ovarian cancer			
High cholesterol				Colon cancer			
Hypertension				Other cancer			
Diabetes							
Osteoporosis							
Breast cancer							

Social History

	Yes	No		Yes	No
Do you smoke? Packs per day ___ yrs ____			Seat belt use		
Ex-smoker? Packs per day ___ yrs ____			Regular exercise		
Use alcohol? Drinks per week ___ yrs ____			Take calcium supplement		
Recreational drug use			Sexually abused or hurt by someone		

One Time Authorization Form

PATIENT'S NAME _____ DATE _____

Assumption of Responsibility: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above named facility all charges for such services and incidentals incurred. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses. Even though insurance may be filed, I understand that all bills are payable upon receipt and that I, and not the insurance company, am responsible for the payment of all services.

INITIAL: _____

Responsibility for copay amounts: I agree to be fully responsible for paying co-pays of set amounts at the time of physician's visit. Further, I understand that if my copay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. This meaning that any bill received, once insurance has paid, will be due upon receipt.

INITIAL: _____

Assumption of referrals: I understand that if I have insurance coverage, which requires a referral from a Primary Care Physician, it must be received in order to receive the maximum benefits from the insurance company, I further understand that it is my responsibility to obtain a hard copy referral from my Primary Care Physician, I have been given the opportunity by the above said provider to obtain a referral or reschedule my appointment. I understand that if I refuse that I am taking full responsibility for payment.

INITIAL: _____

Assignment of Insurance Benefits: I hereby assign direct payment of any hospital insurance benefits, medical insurance benefits, including Medicare, Medigap, major medical benefits, insurance disability benefits, or injury benefits payable because of liability of as third party or organization, and so forth, payable to or for the above said patient until account is paid in full.

INITIAL: _____

SIGNATURE _____ DATE _____

Acknowledgement of Receipt of Privacy Notice.- I acknowledge receiving today a copy of the provider's notice of privacy Policies- I consent to the provider's use of protected health information as described in the notice for treatment, payment, of health care operations- I understand that I must provide a separate authorization before any other disclosures may be made.

INITIAL: _____

Rem Reminder / notification: We may call you to remind you of your appointment or notify you of test results. I agree, if I have an answering machine, to allow the doctor or staff members to identify themselves, as well as myself and to notify me of my appointment or tell me that test results are back. We will not leave test results on your answering machine.

INITIAL: _____

SIGNATURE _____ DATE _____

Request for restrictions: I request that my protected health information be disclosed to the following persons or facility (please list): _____

SIGNATURE _____ DATE _____

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