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: _____

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PATIENT INFORMATION AND HISTORY AUTHORIZATIONS

I hereby authorize Parkwest Gynecology, P.C. to submit a sample of my blood to test for HIV or any potentially life threatening condition should a staff member encounter exposure.

_____ _____
Signature of Authorized Representative Date

_____ _____
Witness Date

I authorize the release to Medicare and/or my commercial insurance carrier of any medical or other information necessary to process claims for medical services.

I request payment of medicare and /or commercial insurance medical benefits to be paid directly to Parkwest Gynecology, P.C..

I understand that payment of my account is ultimately my responsibility and not my insurance carrier's. I hereby agree that if my account becomes delinquent and collection action by an outside agency becomes necessary that I will be responsible for the 30% collection fee charged by the agency. I understand that if I have not secured appropriate authorizations or otherwise complied with the terms of my benefit plan that there may be decrease in my insurance coverage or no coverage at all for some or all of the services which I may receive or be referred for by my primary care physician. I understand that I will be financially responsible for any non-covered services.

I acknowledge that in consideration of other patients, a 24 hour notice of cancellation is required by this office and failure to do so could result in a $30.00 charge that is not covered by insurance and would be payable from myself or my authorized representative.

I am aware that any checks returned from the bank with no payment will result in a $40.00 fee added to my account I also acknowledge if the returned check fee, as well as the original amount of the returned check, are not paid with in 10 business days after notification, my account will be sent to an outside agency for collective action and I will be responsible for the charges incurred for that as well.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Witness Date

Reason for your appointment: ____Annual Check Up ____Problem Visit ____Follow Up ____Post Op

Past Medical History (Please Check All That Apply To You)

____Asthma
____Seasonal Allergies
____Anemia
____Blood Clots
____Bowel Problems(Irritable Bowel)
____Blood Transfusions
____Cancer – Type _____
____Diabetes
____Depression
____Epilepsy (Seizures)
____Eating Disorder
____Gallbladder Problems
____Heart Disease
____Migraines
____Other_____

____High Blood Pressure
____Hiv/Aids
____Hepatitis/Liver Disease
____Kidney Stones
____Kidney Disease
____Lupus
____Rheumatic Fever
____Reflux
____Ulcers
____Sexually Transmitted Disease
____Stroke
____Thyroid
____Tuberculosis
____History of treatment for alcohol/drug abuse
____Abnormal Cholesterol Level

Past Surgical History

General Surgery

____Skin Cancer (Malignant Melanoma)
____Cataract Surgery
____Tonsils
____Wisdom Teeth
____Heart Surgery
____Thyroid Surgery
____Gallbladder
____Bowel Surgery
____Appendectomy
____Hernia Repair
____Orthopedic Surgery (Knee, Hip, Shoulder, etc…)
____Gastric Bypass
____Other _____

Cosmetic Surgery

____Breast Implants
____Breast Reduction
____Abdominoplasty (Tummy Tuck)
____Face Lift

Gynecological Surgery

____Tubal Ligation
____D&C
____Hysterectomy: (Please Circle)
Abdominal, Vaginal, Supracervical
____Ovary Removal: (Please Circle)
Right, Left, Both
____Endometrial Ablation
____Bladder Surgery
____Prolapse Surgery: (Please Circle)
Bladder, Rectocele
____Laparoscopy
____Tubal Pregnancy
____Breast Surgery: (Please Circle)
Biopsy, Mastectomy, Lumpectomy
____Other _____
_____

Obstetric History

Pregnancies:

Date	Gender	Length of Pregnancy	Weight	Vag/C-section	Complications
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

#Miscarriage(s) ____ #Elective Termination(s)____ #Tubal (Ectopic) Pregnancy(s) ____

Patient Name _____DOB_____

Gynecological History

Date of Last Menstrual period _____ Periods:(Please Circle) Regular Irregular Menopausal None due to surgery

Irregular Periods: ____Skipping Cycles____ Bleeding between cycles ____Longest interval between periods(#days)

Bleeding: Usual # of days with bleeding_____Volume (Please Circle) Light Moderate Heavy Clots

Cramps (Please Circle) Minimal Moderate Severe

Menopausal: Age periods stopped____Current hormone replacement therapy____(Yes/No) Previous hormone replacement therapy____(Yes/No) Post menopausal bleeding ____(Yes/No)

Pap Smear: Date of last pap_____Pap Result (Please Circle) Normal Abnormal

Abnormal Pap: (Please circle type of treatment) Repeat pap Colposcopy Biopsy Cryo Surgery

Leep Procedure No follow up Date of treatment_____

Mammogram Performed: Yes No Date_____Facility where performed_____

Abnormal Mammogram: Yes No (Please circle if had) Breast Ultrasound Breast Needle Biopsy Breast Surgery

Sexual History: Sexually active: Yes No ____# of lifetime partners ____# years with current partner
History of the following STD:____Gonorrhea____Chlamydia____Herpes____Trichamonas____Syphyllis____HPV
HIV____ Condyloma____Other: _____Do You Desire STD Testing ____Yes ____ No
Birth Control Method_____

Sexual Problems (Please Circle) Pain Dryness Low desire Other_____

History of sexual abuse: Yes No (Please Circle) Reported Unreported Counseling Obtained

Genitourinary History

Incontinence Yes No (Please Circle) Leaking with cough or sneeze Urgency (Can't get to restroom in time)

Bone Health

Bone Density Study Performed: Yes No Date of Last Test _____ Location Test Was Perfomed _____
Medication Prescribed: Yes No Medication Name _____Calcium ____Vitamin D____

Colon Health

Colonoscopy Performed: Yes No Location Test Was Performed _____ Date _____

	Family History			**(Please Circle)**
Breast Cancer	Yes No _____	Relationship _____	Age at Diagnosis	Alive / Deceased
Ovarian Cancer	Yes No _____	Relationship _____	Age at Diagnosis	Alive / Deceased
Colon Cancer	Yes No _____	Relationship _____	Age at Diagnosis	Alive / Deceased
Other Cancer	Yes No _____	Relationship _____	Age at Diagnosis	Alive / Deceased
Heart Disease	Yes No _____	Relationship _____	Age at Diagnosis	Alive / Deceased
Hypertension	Yes No _____	Relationship _____	Age at Diagnosis	Alive / Deceased
Diabetes	Yes No _____	Relationship _____	Age at Diagnosis	Alive / Deceased
Osteoporosis	Yes No _____	Relationship _____	Age at Diagnosis	Alive / Deceased
Blood/Clotting Disorder	Yes No _____	Relationship _____	Age at Diagnosis	Alive / Deceased

Patient Name_____DOB_____

Social History

Please Circle Race: (White) (Black or African American) (Asian) (Refuse) (Other) Please list_____

Please Circle Ethnicity: (Hispanic or Latino) (Not Hispanic or Latino) (Refuse)

Occupation: _____Level of Education (Please Circle) High School College Trade School

Please Circle Status: Single Married Divorced Widowed Domestic Partner

Current Smoker: Yes No ____#Packs per Day ____#Years Smoked

Previous Smoker: Yes No ____#Packs per Day ____#Years Smoked ____#Years Quit

Alcohol: Yes No ____# Drinks Consumed Per Week

Caffeine: Yes No ____# Drinks Consumed Per Day

Aspirin: Yes No ____# Consumed Per Day ____# Consumed Per Week

Illicit Drug Use: Yes No ____ Seldom Use ____Never Use ____ Occasionally Use ____ Daily Use

Exercise: Yes No _____ Method (Walking, Jogging, Cardio) ____# Hours Per Week

Allergies

Medication Allergies	Reaction	Medication Allergies	Reaction

Foods (Shellfish, Peanuts etc…)	Reaction	Foods	Reaction

Environment(Latex, Nickel, Tape etc)	Reaction	Environmental	Reaction

Medications

(Include eye drops, injections, topical, pellets, vitamins and dietary supplements)

Medication	Dosage	How Often/# Taken	Prescribing Physician	Condition

Patient Name _____DOB_____Pharmacy Name_____Phone#_____

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

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