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: _______________________

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** |
|---|---|---|---|---|
| | | | | |
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| | | | | |
| | | | | |

**Patient Name _________________________DOB__________Pharmacy Name_______________Phone#________**

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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

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 1, 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

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