Patient Registration Form

Name: ____ Date of Birth: ____/_____/__________
First Middle Last

Social Security Number: _______-______-_________ Marital Status: Single Married Divorced Separated Widowed Race: _______________ Hispanic or Latino? Yes No

Gender Identity: ______________________ Preferred Pronouns: ________________________

Mailing Address: ____
Street Apt/Ste # City State Zip Code

Mobile Phone: ________________________ Home Phone: _____________________ Work Phone: _________________________ Email: ___________________________________

How would you like to receive appointment reminders/confirmations?

Text __ Email __ Cell __ Home __ Work __

Emergency Contact: ____ Phone: _________________________ Relationship: ______________________

Emergency Contact: ____ Phone: _________________________ Relationship ______________________

Employer: ____ Occupation: ____

Preferred Pharmacy: ____
Name Address Zip Code

Insurance Information

Primary:

Insurance Co: _______________________________ Policy #: ________________________________ Group #: ____________________

Policy Holder: _______________________________ Date of Birth: ____/_____/________ SSN:______-_____-_________

Relationship to Insured: ________________________

Secondary (If applicable):

Insurance Co: _______________________________________ Policy #: _____________________________ Group #: _______________

Policy Holder: _________________ Date of Birth: ___/___/_____ SSN: ___-__-_____ Relationship to insured: _________________

Who is responsible for payment today and any remaining balance? (MUST be 18 or older)

Name: _____________________________________ Date of Birth (for proof of age):____/____/_______ Relationship: ______________________

Please Remember: Our charges are due at the time services are performed. Payment is your obligation regardless of insurance or third party involvement, unless we are a participating member of your PPO or HMO.

Assignment and Release: By signing below I authorize payment of insurance benefits to be paid directly to Advanced Health Partners, dba Hendersonville Obstetrics and Gynecology. I also authorize Hendersonville Obstetrics and Gynecology to release any information required to process the claim. I further understand and agree that if the accounts for which I am responsible become delinquent, I will pay for all costs associated with the collection process. These may include , but would not be limited to, collection fees, attorney's fees and court costs.

____ _____________

Signature Date

Patient Consent Form

Patient Name:____________________________________ Date of Birth: __________________

(Please Read and Sign)

I, ____________________________________, hereby consent to the following Treatment:
Patient's First and Last Name

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Hendersonville Obstetrics and Gynecology may include consent at satellite offices under common ownership.

I, the undersigned, authorize Hendersonville Obstetrics and Gynecology to use and disclose my information for the purposes of treatment, payment and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize the release of medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Hendersonville Obstetrics and Gynecology.

I acknowledge that I have been given the Hendersonville Obstetrics and Gynecology Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____________________________________ ____________
Signature Date

HIPAA Release Form

Patient Name:____ Date of Birth: ______________________

Release of Information:

__ I authorize the release of information including any medical information, any diagnostic test results, and/or financial information.

This information may be released to:

__ Spouse ____________________________

__ Child(ren) ___________________________

__ Other______________________________

__ Information is not to be released to anyone

Messages:

Please Call:

__ My home number: __________________________________

__ My work number: __________________________________

__ My cell number: ___________________________________

__ Email: ____

If unable to reach me:

__ You may leave a detailed message.

__ Leave a message asking me to return your call.

__ Do not leave a message.

This release of Information will remain in effect until terminated by me in writing.

____ ______________

Signature Date

Declaration Sheet

Patient Name:____ Date of Birth: ___________________

Chose the visit you wish to be seen for today (Please choose only one):

_______ Wellness Visit

The Wellness Visit includes pelvic/breast exam, pap smear if appropriate, a routine health screening, and yearly prescription refill. If you have had a Wellness visit with your Primary Care Provider during your wellness visit time frame, you may be responsible for today's charges.

***MEDICARE/MEDICARE ADVANTAGE PATIENTS:** IF YOU HAVE RECEIVED ANY WELLCARE FROM ANY OTHER PROVIDER WITHIN THE YEAR, THIS VISIT WILL NOT BE COVERED.*

I understand and if my visit is not covered, I will be responsible for any non-covered charges. (please initial): _______

_______ Pregnancy

_______ Problem Visit

You have specific concerns you want to discuss/treated**.** This will be subject to my deductible and copay.

Please select the type of insurance for today's visit:

_______ **Commercial Insurance** (through an employer/marketplace) **Copays are due at the time of service for problem visits**.

_______ **Tenncare** (Bluecare, Amerigroup/Wellpoint, UHC Community Plan - had to apply through the State of TN)

_______ **Cost-Savings Program** (Medi-share)

_______ **Self-pay** - Payment is due at the time of service

_______ **Medicare/Medicare Advantage***

ATTENION MEDICARE/MEDICARE ADVANTAGE PATIENTS: Preventative/Wellness care is NOT covered at the Gynecologist. Breast/Pelvic exams and pap smears are **only covered every 24 MONTHS** and will be billed with a problem visit. You will be responsible for any non-covered charges and copays.

____ ____________

Signature Date

Health History

Patient Name:____ Date of Birth: ________________ Today's Date: _____________

Menstrual History:

Date of last menstrual period: _______________ How often do you have your period? _______________ Is your bleeding: ☐ Light ☐ Moderate ☐ Heavy

What age did your periods start? _______________ How many days do your periods last? _______________ Do you have spotting or bleeding between periods? ☐ Yes ☐ No

Menstrual Symptoms: (Please check all that apply)
☐ Cramps ☐ Severe Pain ☐ Bloating ☐ Breast Tenderness ☐ Severe Emotional Change ☐ Nausea

Post-Menopausal:

What age did your periods stop? ____ Are you experiencing any vaginal bleeding? ☐ Yes ☐ No

Have you ever been on hormone replacement therapy? ☐ Yes ☐ No if yes, please list type: ___________________________

Gynecological History:

Approximate date of last gynecological exam? _______________ Did you have a pap smear at that visit? ☐ Yes ☐ No

Did you have a breast exam at your last gynecological visit? ☐ Yes ☐ No Have you had a mammogram? ☐ Yes ☐ No

Date of most recent mammogram? _______________ Have you had a colonoscopy? ☐ Yes ☐ No Date of colonoscopy: _______________

Check if you have had any of the following:

☐ Abnormal Pap ☐ Positive HPV test ☐ Genital Herpes ☐ Gonorrhea ☐ Chlamydia ☐ Pelvic Inflammatory Disease (PID)

☐ Frequent Urinary Tract Infection ☐ Ovarian Cyst ☐ Endometriosis ☐ Fibroid Uterus ☐ Infertility

Sexual History:

Are you sexually active? ☐ Yes ☐ No with: ☐ Men ☐ Women ☐ Both

Do you experience pain or other difficulties with sexual activities? ☐ Yes ☐ No

If yes, specify:____

Contraceptive History:

☐ none (does not apply)

What form of birth control are you currently using? ☐ Condoms ☐ Birth Control Pills ☐ Depo Provera ☐ Patch ☐ Mirena ☐ Kyleena ☐ Nexplanon ☐ Diaphragm ☐ Spermicide ☐ Withdrawal ☐ Other: ______________________________

Other methods used in the past: ____

Are you interested in changing the type of your birth control? ☐ Yes ☐ No

Patient Name:____ Date of Birth: __________________ Today's Date: _______________

Obstetrical History:

Have you ever been pregnant? ☐ Yes ☐ No (If no, please skip)

Number of Pregnancies: _____ Full-Term Deliveries: ____ Premature Birth: ____ Stillborn: ____ Miscarriage: ____ Elective Termination: ____

Date of birth:	Sex:	Birth Weight:	Pregnancy Duration:	Vaginal or C-Section:	Delivered where?:	Present Health:

Medications:

Please list all current medications including non-prescriptions medications:

Medication Name:	Dose:	Frequency:

Do you have any drug allergies? ☐ Yes ☐ No If you yes, please below:

____

____

Do you have any non-medication allergies? ☐ Yes ☐ No
☐ Latex ☐ Iodine ☐ CT contrast dye ☐ Bee stings ☐ Shell fish ☐ Other: ________________________

Do you have an objection to receiving blood products in the case of an emergency? ☐ Yes ☐ No

Did you receive a flu vaccine this year? ☐ Yes ☐ No Date of flu shot: ____________________

Patient Name:_______________________________ Date of Birth: ____________ Today's Date: __________

SURGICAL HISTORY:

Please list all the surgeries you have had:

Surgery	Date/Year performed

HEALTH HISTORY:

Do you currently smoke cigarettes? ☐No, never ☐ Exposure to secondhand smoke

☐ Yes amount per day _________ how many years ____ ☐ Quit Date stopped: _________

Do you drink alcohol? ☐ Yes ☐ No If yes, how much per month? _________________

Do you use recreational drugs? ☐ Yes ☐ No ☐ past user If yes, what drug(s)? ________________________

Please list all medical problems you have or have had:

____

PLEASE CHECK ALL THAT APPLY

Breast Cancer	☐ Self	☐ Family	Thyroid Problems	☐ Self	☐ Family
Ovarian Cancer	☐ Self	☐ Family	Migraines	☐ Self	☐ Family
Uterine Cancer	☐ Self	☐ Family	Depression	☐ Self	☐ Family
Cervical Cancer	☐ Self	☐ Family	Elevated Cholesterol	☐ Self	☐ Family
Colon Cancer	☐ Self	☐ Family	Liver Disease	☐ Self	☐ Family
High Blood Pressure	☐ Self	☐ Family	Kidney Disease	☐ Self	☐ Family
Diabetes	☐ Self	☐ Family	Bleeding Disorders	☐ Self	☐ Family
Stroke	☐ Self	☐ Family	Gallbladder Disease	☐ Self	☐ Family
Heart Disease	☐ Self	☐ Family	Other:	☐ Self	☐ Family
Seizures	☐ Self	☐ Family			