Patient Registration Information

First Name:_____ Middle:_____ Last:_____ Sex: M___ F:___
Birth Date:_____ Soc. Sec #_____-_____-_____ Driver License # _____
Address:_____ City/State/Zip:_____
Home #: ( )_____ Work # ( )_____ Cell #: ( )_____
Email Address:_____Primary Care Physician_____
Race: _____ Marital Status: _____ Referring Physician/Person:_____
Patient's Employer: _____ Occupation:_____
Address:_____ City/State/Zip:_____
For appointment reminders or call back request or information regarding your health, OK to leave messages on (Please circle all that apply) Home Phone Number Work Phone Number Cell Phone Number
Which number is your preferred contact? _____
Is it OK to leave messages with family members? Yes_____ No _____
Who can we release information to?_____ Relation:_____
For current information can we retrieve your medication list from your Pharmacy? Yes_____ No _____

Emergency Contact/ Legal Guardian Information

Name:_____ Relationship:_____
Address: _____
Home Telephone: ( ) _____ Cell Phone: ( ) _____

Insurance Policy Holder's Information *REQUIRED*

○ Self OR Name:_____ Birth Date: _____
Soc. Sec #: _____-____-_____ Sex: M_____ F _____ Relation:_____
Address if different than above: _____
Home Telephone: ( )_____ Cell Phone: ( )_____
Employer_____
Address:_____ City/State/Zip:_____
Occupation:_____ Work Phone: ( )_____

Primary Insurance

Company Name: _____ Member Name:_____
ID#_____ Group # _____

Secondary Insurance

Company Name:_____ Member Name: _____
ID#_____ Group # _____

Pharmacy Information

Pharmacy Name:_____ City:_____ Phone Number: _____

I hereby grant permission to Cookeville Gynecology to employ such medical, surgical, and x-ray procedures as my doctor may consider necessary in my diagnosis and treatment. I authorize the holder of medical or other information to release to my insurance carrier, governmental agency, or its intermediary, any information needed for this or a related insurance claim. I agree to pay any charges incurred by me to Cookeville Gynecology.

_____ _____
Signature of Patient (Parent if Patient is a Minor) Date

Cookeville Gynecology Financial Policies

Insurance: Insurance coverage is a contract between you and your insurance company. Each policy is different and it is the member's responsibility to understand their benefits, eligibility dates, and covered benefits. If the insurance company does not process and pay a claim, the payment of the account will become the responsibility of the patient or legal guardian. We must have a current copy of your insurance card on file at all times. If your insurance changes, it is your responsibility to inform us of the effective dates of your new policy. It is your responsibility to know if your provider is considered "In network" by your insurance. If your medical insurance company requires a referral to see a specialist, you are responsible for ensuring that the referral has taken place.

Co-pays, Co-Insurances, & Deductibles: I understand that any co-payments, co-insurance, or deductible is due from me at the time of service. I understand that I am responsible for any balance not covered by my insurance.

Non-covered services: It is possible that your insurance may not cover certain procedures or treatment of certain diagnoses. You will be responsible for any non-covered services.

Payment and Returned Checks: We accept cash, check, money orders, VISA, Mastercard, and debit cards for payment. In the event of default, a **$20 fee** will be added to my account balance after the third statement and my account will be sent to Collections. **There will be a $30 fee for returned checks.**

No Show: We understand that situations arise in which you must cancel an appointment. In fairness to other patients, we request 24 hours notice to cancel an appointment. Patients who cancel within 24 hours of the appointment or fail to attend the appointment will be considered a **No Show and will be subject to a $25 fee.** Missing more than two appointments without providing notice are grounds for discharge from the practice.

Outside Lab Services: For labs not performed by our staff, we use PathGroup. Charges for these services are not controlled by Cookeville Gynecology. Patients are responsible for knowing whether their insurance plan covers laboratory services and for making arrangement for payment with the lab.

I agree to the above financial policies. Print Patient's Name: _____

_____ _____ _____

Signature of Patient or Representative | Relationship to Patient | Date

NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I understand that, under the HIPAA Privacy Rule, I have certain rights to privacy regarding my protected health information. I further understand that this information can and may be used for any of the following:

1. To conduct, plan and direct my care and follow-up with the multiple healthcare providers who may be directly or indirectly involved in the treatment(s).
2. To obtain payment from third party payers (insurance, etc.)
3. To conduct normal and required healthcare operations such as quality assessments.

I have been informed by Cookeville Gynecology of their Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have the right to review the entire Notice of Privacy Practices prior to signing this consent.

By signing this form, I am consenting to Cookeville Gynecology's use and disclosure of my PHI to carry out treatment, payment, and operations. I authorize payment of insurance benefits to Cookeville Gynecology. I authorize Cookeville Gynecology to access my medication history electronically without limitation or exclusion as is required and/or reasonably advisable for the purpose of my care and treatment. I consent to receive automated calls and /or messages regarding appointments, test results, and billing.

Signature of Patient or Legal Representative: _____ Date: _____

Print Patient's Name: _____ Print Legal Representative's Name: _____

Name: _____ **DOB:** _____ **Pharmacy:** _____

Primary Care Provider: _____ **Referring Provider:** _____

Allergies (Medications, Latex, IVP dye, Food)

_____

Medications (Prescription and OTC, or a list may be given to the staff)

_____

_____

_____

Vaccines Last Flu Shot: _____ Last Pneumonia Shot: _____

Gynecological History

Age of first menstrual period: _____
Date of LMP: _____ Menses monthly? YES NO
Flow: Light Moderate Heavy Duration of flow? _____ days
Are you currently sexually active? YES NO Have you ever been sexually active? YES NO
Do you use birth control? YES NO Current birth control method? _____
Date of last Pap smear: _____ Date of last mammogram: _____
If postmenopausal, age at menopause: _____
Have you received the HPV vaccine? YES NO

OB History

Total pregnancies: _____ Number of full term: _____ Premature: _____
Elective abortions: _____ Miscarriages: _____ Ectopics: _____
Multiple births: _____ Living children: _____

Family History (Parents, grandparents, siblings, aunts, uncles, and children)

Blood clotting disorder? YES NO If yes, who? _____ Maternal or Paternal
Stroke? YES NO If yes, who? _____ Maternal or Paternal
Diabetes mellitus ? YES NO If yes, who? _____ Maternal or Paternal
Heart disease? YES NO If yes, who? _____ Maternal or Paternal
Hypertensive disorder? YES NO If yes, who? _____ Maternal or Paternal
Cancer of uterus? YES NO If yes, who? _____ Maternal or Paternal
Breast cancer? YES NO If yes, who? _____ Age diagnosed? _____ Maternal or Paternal
Cancer of cervix? YES NO If yes, who? _____ Maternal or Paternal
Colon cancer? YES NO If yes, who? _____ Age diagnosed? _____ Maternal or Paternal
Lung cancer? YES NO If yes, who? _____ Maternal or Paternal
Ovarian cancer? YES NO If yes, who? _____ Age diagnosed? _____ Maternal or Paternal
Osteoporosis? YES NO If yes, who? _____ Maternal or Paternal
Substance abuse? YES NO If yes, who? _____ Maternal or Paternal
Other Cancer? YES NO If yes, who? _____ Maternal or Paternal

Social History

Do you smoke or use chewing tobacco? YES NO
Smoking - How much? _____ Years of use: _____
Do you consume alcohol? YES NO Alcohol intake: _____
Do you consume caffeine? YES NO
Do you use illegal drugs? YES NO
Do you exercise? YES NO Frequency? _____
Marital status: _____ Number of children: _____
Highest level of education: _____ Occupation: _____
Employer: _____

Do you refuse to accept blood for religious reasons? YES NO
Do you experience urinary leakage or difficulty making it to the restroom? YES NO
Are you currently under the care of a pain clinic? YES NO
Date of last colonoscopy: _____
Do you have an advance directive (living will or medical power of attorney)? YES NO
Have you been to the Emergency Room in the past 3 months? YES NO
Are you able to care for yourself? YES NO
Do you have difficulty concentrating, remembering or making decisions? YES NO
Do you have difficulty walking or climbing stairs? YES NO

Surgical History (Side/Year)

Appendectomy	_____	Breast Biopsy **R L**	_____	Breast Implants	_____
Breast reduction	_____	Cesarean Section	_____	Cholecystectomy	_____
Colon surgery	_____	Colonoscopy	_____	D&C	_____
Ectopic Pregnancy	_____	Endometrial Ablation	_____	Hysterectomy	_____
Hysteroscopy	_____	Laparoscopy	_____	LEEP	_____
Mastectomy **R L**	_____	Removal of ovary **R L**	_____	Thyroid Surgery	_____
Tonsillectomy	_____	Tubal Ligation	_____	Other:	_____

Past Medical History

Anemia	**YES NO**	Anesthesia complications	**YES NO**	Anxiety Disorder	**YES NO**
Arthritis	**YES NO**	Asthma	**YES NO**	Blood/bleeding disorder	**YES NO**
Breast Cancer	**YES NO**	Breast Problem	**YES NO**	Cancer	**YES NO**
Depression	**YES NO**	Diabetes	**YES NO**	Endometriosis	**YES NO**
GI Problems	**YES NO**	Headaches or Migraines	**YES NO**	Heart Disease	**YES NO**
Hepatitis	**YES NO**	High Blood Pressure	**YES NO**	History of STD	**YES NO**
Infertility/Repeated miscarriage	**YES NO**	Kidney or Bladder Problems	**YES NO**		
Lung Disease	**YES NO**	Ovarian Cancer	**YES NO**	Thyroid Problems	**YES NO**

Please circle if you currently have any of these symptoms:

Constitutional: fatigue fever weight gain (___lbs) weight loss (___ lbs)

Skin: abnormal mole rash nipple discharge

Eyes: irritation vision changes

ENMT: hearing loss ear pain nose/sinus problems sore throat snoring dry mouth mouth ulcer

Respiratory: shortness of breath cough sputum production spitting /coughing up blood wheezing

Cardiovascular: chest pain palpitations

Gastrointestinal: heartburn difficulty swallowing nausea vomiting abdominal pain bowel movement changes diarrhea constipation rectal bleeding

Genitourinary: abnormal bleeding dysuria incontinence discharge vaginal itching

Endocrine: Menstrual: premenstrual symptoms Menopausal: menopausal symptoms
Sexual: decreased libido orgasmic dysfunction painful intercourse

Musculoskeletal: muscle aches or weakness arthralgias/joint pain

Neurologic: headaches dizziness weakness numbness seizures

Psychological: depression alcoholism sleep disturbances

Hematologic/Lymphatic symptoms: easy bruising tendency swollen glands

Cookeville Gynecology

Name_____ **Phone #**_____

Which symptoms best describe you?

- ☐ Frequent Urination – Day, Night, or Both
- ☐ Sudden or Strong Urge to Urinate
- ☐ Unable to Empty the Bladder
- ☐ Leaking with Sneezing, Coughing, etc
- ☐ Leaking with Urge or No Warning
- ☐ Bladder or Pelvic Pain

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? **Yes** **No**

If yes, check the medications you have tried:

- ☐ Detrol® LA
- ☐ Ditropan XL®
- ☐ Flomax®
- ☐ Cardura®
- ☐ Oxytrol® Patch
- ☐ Enablex®
- ☐ VESIcare®
- ☐ DDAVP®
- ☐ Sanctura®
- ☐ Elavil®
- ☐ Elmiron®

Did these medications help your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

No Relief **Completely Cured**

If you have stopped taking your medication explain why:

☐ Did Not Help ☐ Side Effects ☐ Too Expensive

Describe Side Effects: _____

_____

Behavior Modifications Attempted:_____

(Examples include caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated **Very Frustrated**

Do you currently have any problems with bowel function? **Yes** **No**

☐ Fecal Incontinence ☐ Constipation ☐ Other: _____