Patient Registration Form – Bluegrass Obstetrics & Gynecology

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_____

Patient's Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _____-____-_____ ☐ Female ☐ Male Date of Birth____/____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Cellular_____ Pager_____

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

Referring Provider Name_____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Social Security Number _____-____-_____ ☐ Female ☐ Male Date of Birth____/____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth____/____/_____ Insured's Social Security Number _____-____-_____

Insurance Company Address_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth____/____/_____ Insured's Social Security Number _____-____-_____

Insurance Company Address_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

Bluegrass OB Gyn
Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following:

- 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
- 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 **Bluegrass OB Gyn** includes consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **Bluegrass OB Gyn** will use and disclose my information for the purposes of treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to **Bluegrass OB Gyn** or benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized person to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood-borne diseases.

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

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and the Public Health Department and appropriate counseling will be offered.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Bluegrass OB Gyn.

I acknowledge that I have been given the **Bluegrass OB Gyn** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

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

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name: _____

Name: _____

Name: _____

_____ _____

Patient (or Responsible Party) Signature ***Date***

Original – Practice HIM.PRI.001, HIM.PRI.007

Revision Date: June 21, 2010

CURRENT HISTORY REVIEW

Name: _____**Date:** _____

Date of Birth _____ **Occupation** _____

What brings you to our office today? (Please describe briefly)_____

Your Medical Problems: _____

Current Medications: _____

Allergies to Medications _____

Past Hospitalizations and Surgery _____

Preferred Pharmacy _____**Pharmacy Number** _____

Does anyone in your family suffer from: (please circle) ☐ Diabetes ☐ Stroke ☐ Heart Disease ☐ High Blood Pressure ☐ Cervical Cancer ☐ Breast Cancer ☐ Thyroid Problems ☐ Ovarian Cancer ☐ Colon Cancer ☐ Uterine Cancer ☐ Other_____

Are you currently having or have you had problems with any of the following within the past year? (please circle)
☐ Weight loss or gain ☐ Fevers ☐ Trouble Sleeping ☐ Chronic fatigue ☐ Excessive bleeding ☐ Easy Bruising ☐ Abnormal thirst ☐ Vision problems ☐ Ringing in ears ☐ Sinus problems ☐ Nose bleeds ☐ Sore throat ☐ Mouth sores ☐ Coughing up blood ☐ Shortness of Breath ☐ Chronic cough ☐ Blood clot in lungs ☐ Painful breathing ☐ Wheezing ☐ Chest pain ☐ Irregular heart beat ☐ Ankle/hand swelling ☐ Bowel changes ☐ Nausea/vomiting ☐ Hemorrhoids ☐ Incomplete urination ☐ Loss of urine ☐ Painful urination ☐ Bloody urine ☐ Muscle weakness ☐ Joint pain ☐ Joint swelling ☐ Clot in leg vein ☐ Frequent/severe headaches ☐ Dizziness ☐ Seizures ☐ Numbness ☐ Trouble walking ☐ Fainting spells ☐ Unwanted hair growth ☐ Unusual lump or growth ☐ Dry skin ☐ Excessive worry ☐ Depression ☐ Frequent crying ☐ Serious thoughts of harming yourself or others ☐ Menstrual Problems ☐ Bloating ☐ Mood changes ☐ Breast changes ☐ PMS issues ☐ Hot Flashes ☐ Night sweats ☐ Breast pain ☐ Breast lump ☐ Nipple discharge ☐ Other breast issue ☐ Vaginal discharge ☐ Vaginal itching/irritation ☐ Vulvar pain ☐ Vulvar lump/growth ☐ Vulvar sores ☐ Sexual/intercourse Problems ☐ Painful Dryness ☐ Possible exposure to STD

Please List The Number Of:	**When was your last:**	**Do you Smoke** yes or no ▼
	Colonoscopy_____	How much _____
Pregnancies _____	Pap smear _____	
Miscarriage _____	Was it normal yes or no ▼	**Do you drink Alcohol** yes or no ▼
Abortions _____	Mammogram _____	How much _____
Of Living Children _____	Was it normal yes or no ▼	
Of Sexual Partners in The Last Year	Bone Density _____	**Do You Use Illegal Drugs** yes or no ▼
_____	Was it normal yes or no ▼	How much _____
	Menstrual Period _____	

HCA Physician Services
Bluegrass Obstetrics & Gynecology
353 New Shackle Island Road, Suite 341C
Hendersonville, TN 37075

Assignment of Benefits

I hereby assign to Bluegrass Obstetrics & Gynecology any insurance or other third-party benefits available for health care services provided to me. I understand that Bluegrass Obstetrics & Gynecology has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Bluegrass Obstetrics & Gynecology, I agree to forward to Bluegrass Obstetrics & Gynecology all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

_____ _____

Signature of Patient/Legal Guardian **Date**