

Patient Registration Form – Bluegrass Obstetrics & Gynecology

(Please Print)

PATIENT INFORMATION

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

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 Ringling 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

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