Amani Women's Center

"Making a difference in women's lives!"

OBGYN offices of:

Bryan Myers, M.D., PC
Melody Harrison, NP-C

Saharra Jewell, APN

Today's Date:__________________

Patient's name:____
Date of Birth:_______________________Age:_________________Social Security #___________________
Mailing Address or P.O. Box________________________City______________________________
State_______Zip Code__________________Sex:_____Home Phone:( )_____________Cell:( )___________
Marital Status:________________________ Email:_____________________
Are you a student?_______Full time________Part time________
Employment________________________Job title___________________________
Employment status: Full time Part time Not Employed Self Employed Retired Military
Name of Spouse (If you are under 21 name of parent)______________________________________
In case of emergency, who may we notify (other than spouse)?
Name_________________Relationship________________Phone_______________________________

Insurance Information

Do you have insurance?_________Name of insurance____
Subscriber name__________________________SS#_________________Date of Birth__________________
Your relationship to subscriber________________________Subscriber phone__________________________
Subscriber mailing address____
Insurance ID#_______________________Group #____________________Employer__________________

Secondary insurance/Name of company____
Subscriber name__________________SS#_________________Date of Birth_________________________
Your relationship to subscriber______________________________Subscriber phone____________________
Subscriber mailing address____
Insurance ID#_________________________________Group #________________Employer_____________

Who is your primary physician?_____________________________ Phone___________________________

Who referred you to our office?____

Who is responsible for this bill?____

161 Shirley Drive, Winchester, TN 37398 931-962-0450 (ofc.) 931-962-0470 (fax) **1034 McArthur St Manchester, TN 37355** (931-954-5111, 931-962-0470)
106 Westside Dr., Tullahoma, TN 37388 931-393-4700 (ofc.) 931-962-0470 (fax)

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I, the undersigned, certify and acknowledge the following:

- I authorize this office to release any health information for the use of treatment, payment, and healthcare operations which include insurance companies, specialists, and other healthcare providers and institutions.
- I am 18 years or older. If you are under 18, your parent or guardian must sign this form.
- I understand that diagnostic tests may be recommended and denial of these tests can result in undiagnosed and untreated health conditions.
- I understand that I am financially responsible for all charges not covered by insurance assignment.
- I assume responsibility for all costs of collections, including financial charge, attorney fees and court costs.
- I have checked and know that my insurance company covers Amani Women's Health as a provider in or out of network.
- I understand that medical treatment carries with it some statistical risks even when performed with the utmost care.
- I understand that all co-pays, deductible amounts, or self pay services are due at the time of service.
- I understand that appointment times are reserved specifically for me and that any necessary changes should be finalized two working days prior to the original appointment or a late cancellation fee may be charged.
- I acknowledge I received the Amani Women's Health privacy notice attached to this form.
- I have accurately answered all the questions here and on the medical history form, and have read all the above information.
- I understand that it is necessary to bring all forms such as disability and FMLA forms in the office one week prior to the time that they are due. I understand that there is a 20.00 fee for these forms.

Signature______________________________________Date signed____

Printed name____

If personal representative signature appears above, please describe authority to do so

____

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Privacy Practices Notice of Acknowledgment

Name:_______________________________________

Acknowledgment

___________I acknowledge that I have been offered the **Notice of Privacy Practices** but declined.

___________I acknowledge that I have been offered the **Notice of Privacy Practices.**

I give my permission to speak to the following on any medical issue:

	Name
_____My spouse	____________________________
_____My child/children	____________________________
_____My caregiver	____________________________
_____Other	____________________________

Check all that apply.

_____I give my permission to leave messages on my answering machine or with anyone answering my personal phone.

_____I give my permission to contact me at my place of employment. If I am unavailable, I give permission for a message to be left to return the call.

_____I give my permission for my physician to fax any information regarding me to another physician's office that may be covering for my doctor, or a physician that I have been referred to.

_____I give my permission for my pharmacy to be contacted regarding my medications. My pharmacy is ____________________________(pharmacy/city).

I will notify this office in writing (verbal will not be accepted) if there is any change in my above permission.

Name:____ Date:____________________________

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Annual Gynecological Update

Name:________________________________ DOB:______________ Date:___________________

Welcome Back! Please take a few minutes to fill out this form to help us update your records.

Reason for today's visit? ______Annual Exam _________Problem Visit

Please list any new medical problems:____
What was the first date of your last period?______________________________________
Please list all allergies:____
Any new medical problems in your family?_______________________________________
Social Status/Life changes (divorce/death/etc)?___________________________________
Please list all surgeries:____
Please list all current medications:____
Please list all allergies to medications:____

General	__ Weight loss	__ Weight gain	__ Fever	__ Fatigue
HEENT	__ Vision changes	__ Hearing loss	__ Sore throat	
CV	__ Chest pain/pressure	__ Irregular heartbeat	__ Swelling of legs	
RESP	__ Shortness of breath	__ Chronic cough	__ Spitting of blood	
GI	__ Bloody stool	__ Nausea/indigestion	__ Vomiting	__ Diarrhea
Urinary	__ Frequent urination	__ Painful urination	__ Loss of Urine	
MS	__ Muscle pain	__ Joint pain	__ Swelling of joint(s)	
Skin	__ Rash	__ Changes in color/size of moles		
Neuro/psych	__ Headaches	__ Depression/Crying spells		
Endocrine	__ Appetite changes	__ Excessive thirst		
Hematology	__ Excessive bleeding	__ Easy bruising	__ Enlarged lymph nodes	

Allergic to latex? ____Yes ____No
Do you smoke cigarettes? ____Yes ____No If so, how much per day?_______________________
Do you drink alcohol? ____Yes ____No If so, how much per week?______________________
Do you use street drugs? ____Yes ____No
Problems with violence at home? ____Yes ____No

Do you perform a monthly self breast exam?_____________Yes_______________No
Last Mammogram check:______________________Last Bone Density testing:_____________________
For those over 40, the date of last sigmoidoscopy/colonoscopy/stool checked for blood?_____________
Does your insurance cover routine, preventative gynecological care?_____Yes___No
What pharmacy do you use for prescriptions?_____________________________________
What physician/clinic do you use for primary care?________________________________

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