7796 Wolf Trail Cv Ste 202
Germantown, TN 38138

Phone (901) 512-6086
Fax (866) 230-7816

PATIENT INFORMATION

Name ____ Age ________ Date of Birth ___________________

Address ________________________________ City __________________ State ________ Zip ___________

Home Phone __________________________ Cell Phone __________________________ Race ___________

Social Security Number __________________________ Married ___ Single ___ Widowed ___ Divorced ___

Occupation _______________________ Name of Employer ____

Employer Address ____Work Number ________________

Email Address ____

Pharmacy Name and Number ____

Emergency Contact Name and Number ____

INSURANCE POLICY HOLDER INFORMATION

Name __________________________________ Address (if different) _______________________________

Home Phone ___________________ Social Security Number ____________________ DOB _____________

Name of Employer __________________________________ Employer Phone ________________________

Employer Address ____

INSURANCE INFORMATION

Primary Insurance _____________________________ Insured Name ________________________________

Policy Number _______________________________ Policy Group Number __________________________

Insurance Claims Address ____

Secondary Insurance ___________________________ Insured Name ________________________________

Policy Number _______________________________ Policy Group Number __________________________

Insurance Claims Address ____

PLEASE READ AND SIGN BELOW

AUTHORIZATION: I hereby give my permission to Bluff City Obstetrics and Gynecology for medical treatment including but not limited to examinations, injections, blood test, diagnostic testing, or medical procedures deemed necessary and authorize Bluff City OBGYN to release any information concerning my treatment and irrevocably assign to them all insurance benefits for my treatment. I understand that I am financially responsible for payment of all charges at the time they are rendered including any charges in excess of my insurance as reasonable and customary, whether covered by Medicare or other insurance. I understand the only TennCare plan Bluff City participates in is BlueCare. I understand that I am responsible for verifying my insurance coverage and pre-certifying my benefits with my insurance company. I also understand that I am responsible for reasonable collection costs and/or stationary fees incurred in the collection of this account. A photocopy of this statement is as valid as the original.

Patient Signature ____ Date ____________________

Bluff City Obstetrics and Gynecology

Confidential Patient Medical History

Name ___________________________________ Date of Birth ___________________ Date ________________

ALLERGIES: Please list any known allergies to medicines, food, or medical products (latex, beta dine, or tape)

__________________ __________________ __________________ __________________

__________________ __________________ __________________ __________________

MEDICATIONS: Including over the counter medications, vitamins, herbs, and any other supplements.

Please list ALL Medications you are taking, Dosage, and how often you take it.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

MEDICAL HISTORY: Please check illnesses or conditions YOU have had.

Birth Control Method

Pregnancies # _______ Living Children # ___________
Deliveries: Vaginal # _____ C-Section # ____ VBAC # ______
Miscarriages # ______ Abortions # _______

☐ Infertility

Age Menstruation began

Menses: ☐ Regular 21 - 35 days apart ☐ Irregular
☐ Duration of menses: _____ days
Menstrual flow: ☐ Mild ☐ Moderate ☐ Severe
☐ Dysmenorrhea (Painful Periods/Cramps)
☐ Uterine Disorder ☐ Fibroids

☐ Abnormal Pap Smear Date: ___________________
☐ Colpo ☐ Cryo ☐ LEEP ☐ CKC
Date(s): ___________________________________

☐ STD ☐ HIV ☐ Chlamydia ☐ Gonorrhea ☐ Herpes

☐ Breast Problems

☐ Cancer: ☐ Breast ☐ Ovarian ☐ Uterine ☐ Colon
☐ Other Cancer:

☐ Diabetes

☐ Thyroid Disorder: ☐ Goiter ☐ Underactive ☐ Overactive

☐ Migraines

☐ Eye Disease

Heart Disease: ☐ Atrial Fibrillation ☐ CHF ☐ CAD
☐ High Cholesterol
☐ High Blood Pressure (HTN)
Lung Disease: ☐ Asthma ☐ COPD ☐ Pneumonia
☐ Sleep Apnea
☐ Kidney Disease
Gastrointestinal Disorders: ☐ Cirrhosis ☐ Crohn's
☐ Diverticulitis GERD (Reflux) ☐ Hepatitis ☐ Irritable Bowel
☐ Ulcerative Colitis
Arthritis: ☐ Osteo ☐ Rheumatoid
☐ Osteopenia ☐ Osteoporosis
☐ Blood Clots in Legs (DVT) ☐ Phlebitis _____________
☐ Blood Transfusion Date(s): ______________
Mental Illness: ☐ Anxiety ☐ Bipolar ☐ Depression
☐ Seizure Disorder / Epilepsy ☐ Stroke
☐ Chicken Pox or ☐ Vaccine
☐ Autoimmune Disorder
☐ DES Exposure
Other History or Hospitalizations: ________________________

SURGICAL HISTORY: Please check operations or procedures with dates.

	Date		Date
☐ Ear Nose Throat Surgery _____________________		☐ Bladder or Kidney Surgery	
☐ Adenoid or Tonsillectomy		Female/Gynecology ☐ C-Section # _________ ☐ Tubal Ligation ☐ Uterine Ablation ☐ Pelvic Laparoscopy ☐ Hysterectomy ☐ D&C	
☐ Thyroid Surgery			
☐ Lung Surgery ☐ Heart Surgery ☐ Stents ☐ Bypass			
☐ Breast Surgery ☐ Biopsy ☐ Lumpectomy ☐ Mastectomy ☐ Reduction ☐ Augmentation		☐ Hysterectomy: ☐ Abdominal ☐ Vaginal ☐ Supracervical ☐ Laparoscopic/Robotic	
☐ Abdominal Surgery ☐ Appendix		☐ Ovary removed ☐ Left ☐ Right ☐ Both	
☐ Gallbladder ☐ Hernia Repair ☐ Other ___________ ☐ Knee Replacement ☐ Hip Replacement ☐ Orthopedic Surgery		Other Surgery: _______________________________	

Name ___________________________________ Date of Birth __________________ Date _______________

SOCIAL HISTORY: Provide the following information about YOURSELF.

Do you exercise regularly? ☐ Yes ☐ No Marital Status? ☐ Single ☐ Married ☐ Divorced	Do you drink alcoholic beverages? ☐ Yes ☐ No How many? _______ More than 3 per day? ☐
Are you sexually active? ☐ Yes ☐ No Work Status: ☐ Part-time ☐ Full-time ☐ Unemployed ☐ Retired ☐ Occupation: ___________________________	Do you use recreational drugs? ☐ Yes ☐ No If yes, which recreational drugs: _________________________ How much? _____________ How often? __________________
Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, how many per day? ____________	Do you use herbal supplement or vitamins? ☐ Yes ☐ No
Tobacco or Cigarettes? ☐ Never Smoked ☐ Former Smoker: Date quit ________ ☐ Current Smoker: Amount per day _______ ☐ Other	Other social history: ___________________________________

FAMILY HISTORY: Check illnesses that have occurred in any of YOUR BLOOD RELATIVES.

	Relative		Relative
☐ Heart Disease ☐ Early Deaths ☐ High Cholesterol ☐ High Blood Pressure		Cancers ☐ Breast ☐ Colon ☐ Cervical ☐ Ovarian ☐ Uterine ☐ Other Cancer	
☐ Asthma		☐ Stroke ☐ Seizure Disorder	
☐ Diabetes ☐ Thyroid Disorder		Other Family History: ☐ Alcoholism ☐ Birth Defects ☐ Drug Abuse ☐ Genetic Disease ☐ Other:	
☐ Gastrointestinal Disorders			
☐ Osteoporosis ☐ Blood or Clotting Disorder			

IMMUNIZATIONS: Please check if you have received these adult immunizations and indicate when.

☐ Tetanus date: ___________ ☐ Tdap date: __________ ☐ Influenza (Flu) date: __________ ☐ Pneumonia date: ____________
☐ Gardasil Series of #3 date(s) ____________

PRENATAL SCREENINGS: Date of last exam.

Complete Physical ____________________________ Colonoscopy _________________________________

Pap Smear __________________________________ DEXA Scan (Bone Density) _____________________

Mammogram ________________________________ Foot Exam (Diabetes) __________________________

Do you have any additional health information not covered? ______________________________________

____

PHARMACY INFORMATION: Where would you like prescriptions sent?

Name _______________________ Phone _____________________ Address _________________________

Patient Signature ____ Date _____________________

BLUFF CITY OBSTETRICS AND GYNECOLOGY

RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received or been allowed to view a copy of Bluff City Obstetrics and Gynecology's Notice of Privacy Practices as required by HIPAA. This notice describes how we may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I have regarding my protected health information.

Initial _______

PATIENT PAYMENT POLICY AND COVERED SERVICES

- It is the policy of Bluff City OB/GYN to collect all patient balances, copays, and deposits due from patients at the time of service.
- If you are an OB patient or for certain medical procedures, our office may contact your insurance carrier to verify your insurance coverage and benefits. An estimation of your contract responsibility will be determined according to the contractual; agreement between Bluff City OB/GYN and your insurance company for those services. We may review your benefits with you to explain your financial obligation to Bluff City OB/GYN, and you may be required to pay a deposit prior to these services being rendered.
- If your insurance claim is denied due to incorrect personal information or incorrect insurance information that you have provided, you will be billed for any unpaid claims for your services, and payment in full will be due immediately.
- If your account or any account that you are responsible is sent to a collection agency due to nonpayment of any balance, you may be dismissed from Bluff City OB/GYN for any future medical care or services. Additionally, you will be responsible to pay for the reasonable collection costs and/or attorney fees associated with the collection of your account.
- Your health insurance plan may not provide coverage for all medical services, tests, and/or procedures that are recommended for your treatment. It is your responsibility to know and understand the services covered by your insurance, or if your insurance does not cover such services, you will be responsible for payment.
- If you do not have medical coverage with insurance for which Bluff City OB/GYN participates or if you are a new patient and cannot supply your valid insurance card for which coverage cannot be determined, you must pay in full at the time of service.
- Certain labs collected may be sent to an outside lab for testing and you may be billed by the reference lab for these lab tests.
- If you are required to have a referral or prior authorization for medical services, it is your responsibility to obtain this.

Initial _______

RETURNED CHECK FEE

Bluff City OB/GYN will charge the patient account $25.00 for any returned check. Initial _______

WELLNESS/ANNUAL VISITS WITH OTHER PROBLEMS

If during your annual/well-woman preventive care exam, you have or used treatment for a problem, if the problem is addressed during the visit in lieu of scheduling a separate appointment, in addition to the preventive exam it may be necessary that a problem visit be billed along with other labs. Testing, and/or procedures, which may be subject to co-pays and/or deductible. Initial _______

FORMS AND PAPERWORK

There is a minimum fee of $20.00 for the release of medical records which is the responsibility of the patient to pay. An additional $0.50 will be charged for each additional page over and above the first 5 pages. Initial _______

PERSONAL INFORMATION AND VERIFICATION

It is our policy to verify your demographic and insurance information at every visit to help ensure that claims are processed timely and accurately. Please bring your insurance card to every visit. Initial _______

CANCELLATION POLICY

We require a 24-hour cancellation notice for any scheduled medical appointment or surgery/procedure. If a patient repeatedly misses or does not show for an appointment, the patient may be dismissed from the practice. No shows may receive a $40.00 charge for not contacting the office for their scheduled office visit and $100.00 for not showing up for a scheduled surgery and/or procedure. Initial _______

Patient Signature ____ Date ______________________