

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)

I was referred by :

Past Hospitalizations and Surgery:

Current Medications:

Allergies to Medications:

Social History

Obstetric History

Gynecologic History

Yes No	How Much	# of pregnancies _____	Last Menstrual Period:	Every _____ Days
___ ___	Smoking _____	# of miscarriages _____		Lasting _____ Days
___ ___	Alcohol _____	# of abortions _____	Last Pap Smear: _____	Normal yes no
___ ___	Illegal Drugs _____	# of living children _____	Last Mammogram _____	Normal yes no
		# of sexual partners in the last year _____	Last Bone Density _____	Normal yes no

Have you or anyone in your family suffered from:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Colon Cancer
<input type="checkbox"/> Stroke	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> Other

Are you currently having or have you had problems with any of the following within the past year?

<p>General</p> <input type="checkbox"/> Weight Loss or Gain <input type="checkbox"/> Fevers ___ Trouble Sleeping ___ Chronic Fatigue ___ Excessive Bleeding ___ Easy Bruising ___ Abnormal Thirst <p>Eyes</p> ___ Itchy, Red Eyes ___ Vision Problems <p>Ears</p> ___ Ear Pain ___ Ringing in Ears ___ Hearing Loss <p>Nose</p> ___ Sinus Problems ___ Nose Bleeds <p>Mouth</p> ___ Sore Throat ___ Mouth Sores ___ Dental Problems	<p>Lungs</p> ___ Coughing Up Blood ___ Shortness of Breath ___ Chronic Cough ___ Blood Clot in the Lungs ___ Painful Breathing ___ Wheezing <p>Cardiovascular</p> ___ Chest Pain ___ Irregular Heart Beat ___ Ankle/Hand Swelling <p>Gastrointestinal</p> ___ Frequent Diarrhea ___ Constipation ___ Bloody Stools ___ Nausea/Vomiting ___ Hemorrhoids <p>Urinary</p> ___ Incomplete Urination ___ Loss of Urine ___ Painful Urination ___ Bloody Urine	<p>Musculoskeletal</p> ___ Muscle Weakness ___ Joint Pains ___ Joint Swelling ___ Clot in Leg Vein <p>Neurologic</p> ___ Frequent/Severe Headaches ___ Dizziness ___ Seizures ___ Numbness ___ Trouble Walking ___ Fainting Spells <p>Skin</p> ___ Acne ___ Unwanted Hair Growth ___ Unusual Lump or Growth ___ Dry Skin <p>Emotional</p> ___ Excessive Worry ___ Depression ___ Frequent Crying ___ Serious thoughts of harming yourself or others	<p>Menstrual Problems</p> ___ Cramps/Pain ___ Heavy Bleeding ___ Too Frequent Periods ___ Bleeding Between Periods ___ Missed a Period ___ Other Period Issue <p>Pre Menstrual Problems</p> ___ Bloating/Swelling ___ Mood Changes ___ Breast Changes ___ Headaches ___ Acne ___ Other PMS Issue <p>Menopause Issues</p> ___ Hot Flashes ___ Night Sweats <p>Breast Problems</p> ___ Breast Pain ___ Breast Lump ___ Nipple Discharge ___ Other Breast Issue	<p>Other Gynecologic Issues</p> ___ Vaginal Discharge ___ Itching/Irritation ___ Vulvar Pain ___ Vulvar lump/growth ___ Vulvar Sores <p>Sexual Problems</p> ___ Painful Intercourse ___ Bleeding after Intercourse ___ Decreased Desire ___ Orgasm Problems ___ Dryness ___ Possible Exposure to STD ___ Other Sexual Issue <p>Would you like to discuss any of the following?</p> ___ Contraception ___ Menopause Issues ___ Pregnancy Issues ___ Self Breast Exam ___ Sexuality Issues ___ STD's ___ Other
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MD Initial _____	Date _____	MD Initial _____	Date _____	MD Initial _____	Date _____
MD Initial _____	Date _____	MD Initial _____	Date _____	MD Initial _____	Date _____

**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