Bluff City Obstetrics and Gynecology

3265 West Sarazens Cr. Suite #101
Memphis, TN 38125
Phone: (901) 512-6086

Patient Information

Name: ____ Age ______ Date of Birth: ____________________

Address: ______________________________City: __________________ State: __________ Zip: _________

Home Phone: _______________________________ Cell Phone: ______________________________________

Social Security Number: ___________________________ ___ Married ___ Single ___ Widowed ___ Divorced

Occupation: ___________________ Name of Employer: _________________ Work Number: _____________

Employer Address: ____ Race: ________________

Preferred Pharmacy Name and Number: ____

Primary Physician Name and Number: ____

In case of Emergency: Name _______________________________________ Number ___________________

INSURANCE POLICY HOLDER INFORMATION

Name: ______________________________ Address (If Different): _____________________________

Home Phone: _________________ Social Security Number:__________________ DOB _________

Name of Employer: ________________________________ Employer Phone: ___________________

Employer's 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 or not 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 considered to be as valid as the original.

Sign: ____ Date: _______________________

Bluff City Obstetrics and Gynecology

Confidential Patient Medical History

Name: ______________________________ Birthdate: _______________ Chart # ________ 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. ______________________________ 6. ______________________________
2. ______________________________ 7. ______________________________
3. ______________________________ 8. ______________________________
4. ______________________________ 9. ______________________________
5. ______________________________ 10. ______________________________

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

Birth Control Method

Pregnancies # _______ Living Children # __________
Deliveries: Vaginal # _____ C-Section # ____ VBAC # ______
Miscarraiges # ______ 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: ________________________________ Birthdate: _______________ Chart # ________ Date: ________

SOCIAL HISTORY: Provide the following information about YOURSELF.

Do you excercise regularly? ❑ Yes ❑ No	Do you drink alcoholic beverages? ❑ Yes ❑ No How many? _______ More than 3 per day? ❑
Marital Status? ❑ Single ❑ Married ❑ Divorced	
Are you sexually active? ❑ Yes ❑ No	Do you use recreational drugs? ❑ Yes ❑ No If yes, which recreational drugs: ____________________ How much? ____________ How often? ______________
Work Status: ❑ Part-time ❑ Full-time ❑ Unemployed ❑ Retired ❑ Occupation: ______________________	
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: ❑ Alchoholism ❑ 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 ____________________________

Please Sign and Date: 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 OBGYN 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 proceedures, our office may contact your insurance carrier to verify your insurance coverage and benefits. An estimation of your of your contract responsibility will be determined according to the contractual; agreement between Bluff City OBGYN and your insurance company for those services. We may review your benefits with you to explain your financial obligation to Bluff City OBGYN, 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 OBGYN 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 OBGYN 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 OBGYN 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 $0.25 will be charged for each additional page over and above the first 20 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 $20.00 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: