Dear: ______________________________

We would like to welcome you to University Urogynecology. We appreciate the trust you have placed in us. You are scheduled to see Dr. Bryce Bowling on _____________ at _________ EST. Please arrive 30 minutes prior to your appointment to allow us to complete your registration. **If you should arrive 10 minutes after your scheduled appointment time listed above, you will be asked to reschedule to a later date!**

Enclosed is the new patient paperwork for your initial visit. *It is imperative that you return the completed packet in the provided pre-paid self-addressed stamped envelope immediately so that we can request the proper records prior to your appointment. Include the name of the physician, along with their contact information and dates pertaining to any surgeries, studies, or procedures related to your diagnosis.* We will require your current insurance card(s) and co-payment.

Parking is available in parking garage H and located across from the fountain circle. Campus parking is $2.00 and is paid as you exit the premises. Enclosed is a map to help you find the correct parking area. We are in Building A on the 2nd floor. We are located in Suite 235 across from the elevators. Please allow 15 minutes for commuting from the parking lot to our office.

If you have any questions, please contact us during our business hours Monday - Friday 8:00 am - 4:30 pm.

Thank you,

UT Urogynecology
# UT UROGYNECOLOGY
## PATIENT REGISTRATION

<table>
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<tr>
<th>Date:</th>
<th>For Internal Use Only:</th>
<th>MRN:</th>
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### PATIENT INFORMATION

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<thead>
<tr>
<th>First Name:</th>
<th>Middle:</th>
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<tbody>
<tr>
<td>Social Security Number:</td>
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<tr>
<td>Home Address:</td>
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<td>Email Address:</td>
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<tr>
<td>Employment Status (Circle One):</td>
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<td>Retired</td>
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<tr>
<td>Employer:</td>
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<tr>
<td>Marital Status (Circle One):</td>
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<td>Single</td>
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<tr>
<td>Referring Physician:</td>
<td>Phone:</td>
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<tr>
<td>How Did You Hear About Our Office:</td>
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### PREFERRED PHARMACY

| Pharmacy Name: | Phone: |

### PRIMARY INSURANCE INFORMATION

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<tr>
<th>Insurance:</th>
<th>ID:</th>
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<tbody>
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### SECONDARY INSURANCE INFORMATION

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<tr>
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### EMERGENCY CONTACT (List TWO)

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### SPOUSE/GUARANTOR/RESPONSIBLE PARTY

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<td>State:</td>
<td>Zip:</td>
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**AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN:** I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay any non-covered services.

---

**SIGNATURE (Patient or Parent if minor)**  
**DATE**
UT Urogynecology Insurance Payment Policy

Thank you for choosing UT Urogynecology. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy of this can be provided to you upon request.

1. **Insurance Plans.** We are providers with Medicare, most Aetna plans, Beech Street, Blue Cross/Blue Shield, Blue Care, Champus-military only, Cigna, the Initial Group, Humana, Americhoice Tenncare, and United Health. We are **not** insured with UHC Secure Horizon. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up to date insurance card, payment in full is required until we are provided with a current copy of your insurance information. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you may have regarding your coverage.

2. **Co-payments.** All co-payments must be paid in full at the time of service. This arrangement is part of your contract with your insurance company. Please help us in upholding your agreement by paying your co-payment at each visit.

3. **Non-Covered Services.** Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by your insurance, even though your physician feels that it is necessary. Our office will file each visit to your insurance company. If they deem that something is not reasonable or necessary, we ask that you submit payment for that item immediately.

4. **Proof of Insurance.** All patients must complete our patient information form before seeing a physician. We will also ask that you complete this form once a year. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of the claim.

5. **Claim submission.** We will submit your claims and assist you in any way we can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. We will pre-collect any expected coinsurance or deductibles prior to scheduling surgeries and procedures. Your insurance benefit is a contract between you and your insurance company. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. If you have Medicare, we will bill you any money’s owed after we have received payment from Medicare and/or a secondary policy that you might have.

6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will also need to have a copy of your new insurance card.

7. **Non-Payment.** If your account is over 90 days past due, you will receive a letter from our billing department. Partial payments are accepted as long as you call them directly to set up the necessary payment plan. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by all guidelines:

_________________________________________                              _____________________
Signature of Patient or Responsible Party                                              Date
Patient Privacy Questionnaire and Notification

Patient Name:________________________________________________ Date of Birth:___________________

I give permission to the physicians and their staff at University Medical Group to leave messages regarding my healthcare in the following manner when I am not available:

**Contact Information:**

I would prefer to be contacted at: ___________________________

______ Home #____________________________________

______ Cell #______________________________________

______ Work #____________________________________

______ Other #____________________________________

______ May ONLY leave information with me. (If you check here, no other choice should be marked).

______ May leave appointment reminders on my answering machine/voicemail.

______ May leave lab results on my answering machine/voicemail.

______ May leave general questions/information on my answering machine/voicemail.

______ May send confidential messages regarding appointments, lab results, or general messages to your patient portal account

______ May leave a message with a call back number only.

**Please list the name of the individual and relationship of anyone we may give information to:**

Name:____________________________________ Relationship:_______________________

Name:____________________________________ Relationship:_______________________

______ May leave appointment reminders with the above listed person

______ May leave lab results with the above listed person

______ May leave general questions/information with the above listed person

______ May discuss billing information with the above listed person

______ I prefer that all healthcare messages be given to the above listed person

If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address. We keep a record of each visit. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your physicians and other clinical staff to provide appropriate care to meet your medical needs. The information in your record is called protected health information. We may disclose your protected health information to other healthcare providers or entities involved in your care.

I understand that my protected health information may be used to coordinate my treatment as described above. I have been offered a copy of the University Health System, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice, UHS, UHS Ventures Inc., Physicians, and other providers practicing at UHS or UHSV facilities and that I should read it carefully. I am aware that the Notice may be changed at any time.

Signature of Patient________________________________________________ Date_____________________
AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(All sections must be completed)

Patient Name: ____________________________________________

Date of Birth: ___________________ SSN: ___________________

Address: __________________________________________________

I hereby authorize the release of medical records to UT Urogynecology for the purpose of Medical Treatment.

Records to be released from: ________________________________

_______________________________________________________________________________

The authorization will expire on: ____________________________

(Date or Event may not exceed one year)

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, Condition or dates of treatment: _______________________

_____ Specific records to be released (example: labs, imaging reports, operative reports):

_______________________________________________________________________________

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance and thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

__________________________ _______________________
Signature of Patient Date
MEDICAL HISTORY QUESTIONNAIRE

Name: ___________________________ Age: _______ Date: ______________

PLEASE PROVIDE THE NAME, ADDRESS, AND OFFICE NUMBER OF YOUR PRIMARY CARE PHYSICIAN AND YOUR GYNECOLOGIST

PCP
Name: ___________________________
Address: __________________________________________________________
Phone: ___________________________
Fax: ___________________________

GYNECOLOGIST
Name: ___________________________
Address: __________________________________________________________
Phone: ___________________________
Fax: ___________________________

Referring Physician: ___________________________

Please list any other Physician’s you would like to receive your records from UT Urogynecology:
_________________________________________           ___________________________________

Please describe, in your own words, the nature of your gynecologic or urologic problems:
____________________________________________________________________________________
____________________________________________________________________________________

ALLERGIES:
Do you have any drug allergies? Yes / No
Please list the drugs that you are allergic to and what happens when you take them:
____________________________________________________________________________________
____________________________________________________________________________________

MEDICAL HISTORY:
As a child, did you have (please circle):

Bladder Infections  Kidney Infections  Other: ___________________________

As an adult, have you had (please circle):

Heart Disease  Reflux/GERD  Psychiatric Illness  Fibromyalgia
High Blood Pressure  Liver Disease  Depression  Blood in Urine
Diabetes  Stomach/Duodenal Ulcers  Anxiety Disorder  Interstitial Cystitis
Anemia  Multiple Sclerosis  Abnormal Pap Smears
Thyroid Disease  Seizure Disorder  Chlamydia
Chronic Cough/Asthma  Parkinson’s Disease  Gonorrhea
Pneumonia  Serious Injury/Accident  Venereal Warts
Glaucoma  Paralysis  HIV
Kidney Disease  Back Problems  Herpes
Frequent Bladder Infections  Stroke  Syphilis
Kidney/Bladder Stones  Blood Clots  Cancer

Type of Cancer: ___________________________
Treatment Performed: ___________________________

Other: ___________________________
SURGICAL HISTORY:
Have you had a hysterectomy?   Yes  /  No
At what age was this performed?  _____________
If yes, for what reason?
What type of incision?  Abdominal  _____________  Vaginal  _____________  Laparoscopic  _____________
Were your ovaries removed?  Yes  /  No
Who performed the hysterectomy?  _____________  What hospital was this performed?  _____________
Have you had any surgeries for incontinence, prolapse, or other bladder problems?  Yes  /  No
At what age was this performed?  _____________
Who performed the surgery?  _____________  What hospital was this performed?  _____________
Please list any other surgeries that you have had in the past and your age at that time:  _____________

FAMILY HISTORY:
Have any first degree relatives had these diseases?  If so, please indicate their relationship to you.
High Blood Pressure  _____________  Diabetes  _____________
Stroke  _____________  Heart Disease  _____________
Breast Cancer  _____________  Kidney Disease  _____________
Ovarian Cancer  _____________  Osteoporosis  _____________
Cancer (please list type)  _____________  Relaxation of uterus or vagina  _____________
Blood Clotting Disorder  _____________  Urinary Incontinence  _____________
Other Family or Hereditary Disease  _____________

SOCIAL HISTORY:
Do you smoke?  Yes  /  No
If yes, how many packs per day?  _____________  How many years?  _____________
Do you drink alcohol?  Yes  /  No
If yes, how many drinks per week?  _____________
Occupation:  _____________  Spouse’s Occupation:  _____________
Current Marital Status:  Married  _____________  Single  _____________  Divorced  _____________  Widowed  _____________
Number of Pregnancies  _____________  Number of Children  _____________
Number of Miscarriages  _____________  Number of Abortions  _____________

SYMPTOM REVIEW:  PLEASE CIRCLE ANY SYMPTOMS YOU’VE HAD IN THE PAST FEW MONTHS:
General Symptoms:  _____________  Hematologic/Allergy:  _____________  Gastrointestinal:  _____________
Fever or Chills  _____________  Clotting Problems  _____________  Abdominal Pain/Bloating  _____________
Change in Appetite  _____________  Swollen Glands  _____________  Diarrhea  _____________
Headache  _____________  Hayfever  _____________  Floating Stools  _____________
Weight loss/Gain > 10 pounds  _____________  Prolonged Bleeding  _____________  Indigestion  _____________
Nausea/Vomiting  _____________  Easy Bruising  _____________  Constipation  _____________
Neurological:  _____________  Endocrine:  _____________  Musculoskeletal:  _____________
Tremors  _____________  Excessive Thirst  _____________  Joint Pain  _____________
Dizzy Spells  _____________  Intolerance to Hot/Cold  _____________  Back Pain  _____________
Numbness  _____________  Excessive Fatigue  _____________  Weakness  _____________
Cardiovascular:  _____________  Skin:  _____________  Gynecologic:  _____________
Chest Pain  _____________  Skin Rash  _____________  Breast Pain/Lump  _____________
Shortness of Breath w/ Exertion  _____________  Boils  _____________  Hot Flashes  _____________
Varicose Veins  _____________  Change in Appearance of Mole  _____________  Vaginal Bleeding  _____________
Swelling of Legs  _____________  Change in Size of Mole  _____________  Vaginal Discharge  _____________
Eyes/Ear/Nose/Throat:  _____________  Respiratory:  _____________  Psychiatric:  _____________
Blurred Vision/Visual Changes  _____________  Wheezing  _____________  Depressive Symptoms  _____________
Ear Infections/Pain  _____________  Frequent Cough  _____________  Thoughts of Suicide  _____________
Ringing in the Ears  _____________  Coughing Up Blood  _____________  Difficulty Remembering  _____________
Sinus Problems  _____________  Trouble Breathing  _____________  Anxiety  _____________
## Medication List

**Patient Name:**_____________________ **DOB** __________

**Allergies**

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<tr>
<th>Medication Name</th>
<th>Directions</th>
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