CONFIDENTIAL PATIENT REGISTRATION

Copies of your insurance cards must be presented and will be copied and verified.
A copy of your driver's license is required.

PATIENT INFORMATION

Name:_____ Social Security #: _____ Race: _____
Address 1: _____ Home Phone #: _____
Address 2: _____ Cell Phone: _____ Date of Birth: _____
City, State, Zip: _____Age: _____
Referring Physician: _____ Primary Physician: _____
Marital Status: [ ]Married [ ]Partnered [ ]Single [ ]Divorced [ ]Widowed Email: _____

PATIENT EMPLOYMENT

Employer Name: _____ Phone: _____

SPOUSE'S INFORMATION

Name: _____ Social Security #: _____ Date of Birth: _____

EMERGENCY CONTACT(S)

Name: _____ Phone: _____
Name: _____ Phone: _____

Tell us how you found us:

[ ]Printed Advertisement [ ]Yellow Pages [ ]Website [ ]Social Media [ ]Referral – Physician / Patient / Friend

Would you like information regarding a living will or Power of Attorney? [ ]Yes [ ]No

Pharmacy of Choice: _____ Address: _____ Phone: _____

Patient Authorization

Regardless of your insurance coverage, you the patient are always responsible for the payment of your charges. A surgical and or obstetrical deposit may be required if necessary. Our office requires that all co-pays be paid prior to being seen by the provider unless you have Medicare, or an insurance our office is contracted with. Office charges are to be paid by cash, check or credit card at the time of service. Counselors are available to discuss large dollar charges and payment schedules.

Authorization & Assignment

I authorize WCG to release any information acquired by my physician/or staff to my insurance carrier(s). I authorize payments directly to my physician. I recognize and accept responsibility for any balance or fees not covered by insurance and agree to pay the balance in a prompt manner. In any event this account is referred to an outside agency, credit reporting bureau or attorney for collection, I agree to pay all attorney fees, collection costs, court costs and/or other expenses incurred in this collection according to the 1989 statutes of the State of Tennessee. I authorize WCG to electronically obtain my medication history.

Patient or Responsible Person's Signature: _____ **Date:** _____

Patient Disclosure and Agreement

Name: _____ Appointment Date: _____

Your insurance contract will not cover more than one of the following visits per day. These visits cannot be combined. If you have more than one of the following we will be happy to schedule an appointment specifically for that reason for another day. This also helps our office respect your time and other patient's time by staying on schedule.

Indicate only one of the following:

_____ **Annual Gynecologic Examination** (breast and pelvic exams, Pap smear, prescription refills)

_____ **Problem or Follow up Examination** (bleeding problems, infections, pain, hormonal problems, menopause, surgery scheduling, contraception counseling, follow up pap smear, postpartum, post-operative etc.)

_____ **Consultation for a Second Opinion or Consultation from a referring physician.**

If you are scheduled for the following, please indicate which one(s). Insurance contracts allow these tests to be performed on the same day as one of the above visits or on a separate day.

_____ **Lab Test/Injections** _____ **Pelvic Ultrasound**

_____ **Urodynamics** _____ **Other**

Patient/Responsible Person's Signature: _____

Acknowledgement of Notice of Privacy Practices

I have been given the opportunity to review the Notice of Privacy Practices and understand that the Notice describes how my protected medical information may be used and disclosed and how I may get access to this information. I have also been given the opportunity to take a copy of the Notice of Privacy Practices for further review.

If for some reason the facility needs to relay my protected health information, i.e. lab results or billing issues, you can either leave or discuss the information with the following individual(s):

1. _____ 2. _____

3. _____ 4. _____

By signing below, I agree to the fore mentioned statements.

_____ _____

Patient Name (Printed) **Date**

_____

Patient Signature (Patient must sign regardless of age)

BLOOD TRANSFUSION

Please circle Yes or No:

Would you accept a blood transfusion if it were medically necessary or for life saving treatment?

If no, please explain _____