Tennessee GYN
Patient Intake Form

Name: _____ Preferred Name: _____

DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home)_____ (Cell)_____

Email: _____ Employer: _____

Marital Status: ❒ Single ❒ Married ❒ Domestic Partner ❒ Separated ❒ Divorced ❒ Widowed

Race: ❒ White ❒ Black ❒ Asian ❒ Prefer not to answer

Ethnicity: ❒ NOT Hispanic/Latino ❒ Central American ❒ Cuban ❒ Dominican ❒ Hispanic/Latino

❒ Latin American ❒ Mexican ❒ Puerto Rican ❒ South American ❒ Spaniard

Insurance Information: ❒ No Insurance ❒ Medicare ❒ Private Insurance

Primary Insurance Company: _____ ID Number: _____

Subscriber Name: _____ D.O.B.: _____

Secondary Insurance Company: _____ ID Number: _____

Subscriber Name: _____ D.O.B.: _____

Specific lab required? ❒ No ❒ Yes If yes, lab name: _____

Preferred Pharmacy: _____ Phone: _____

Location: _____

Primary Care Physician: _____ Phone: _____

Mammogram Clinic: _____ Phone: _____

Emergency Contact: _____ Phone:_____

Relationship to Patient: _____

How did you hear about our practice? ❒ Patient in Practice: _____

❒ Primary Care Physician ❒ Specialist ❒ Insurance Company ❒ Internet Search ❒ Other

TENNESSEE GYN
SUSAN E WEBB M.D.

ACKNOWLEDGEMENT OF REVIEW
OF NOTICE OF PRIVACY PRACTICES

I have reviewed and/or received a copy of the **Notice of Privacy Practices** for Tennessee GYN/Susan E. Webb M.D. and I authorize the release of my **Protected Health Information** as outlined in the policy. This authorization will remain in effect until revoked in writing. A photocopy of this release is to be considered as valid as the original.

Tennessee GYN/Susan E Webb M.D. has my permission to discuss/leave appointment & medical information with:

Please initial the recipient / method that you approve:

_____ Patient **ONLY**

_____ Spouse/Partner Name: _____

_____ Parent/Caregiver Name: _____

_____ Anyone in my home

_____ Cell phone/voice mail

_____ Email: _____

_____ At home answering machine

Patient Name (please print): _____

Patient Signature: _____

Patient Representative Name/Relationship to Patient (parent/guardian if minor or guardian/POA if adult): _____

Patient Representative Signature: _____

Date: _____

TENNESSEE GYN
SUSAN E WEBB M.D.

PATIENT BROCHURE

PLEASE READ & INITIAL EACH ITEM BELOW

_____ **Responsibility for changes**: I understand that it is my responsibility to notify this office of any changes in my address, phone number or insurance coverage.

_____ **Release for Medication History**: I authorize Tennessee GYN to download my medication history automatically from pharmacy benefit managers. (OPTIONAL)

_____ **Release for Patient Record Sharing**: I authorize Tennessee GYN to share and receive my medical records with my other providers at connected care locations. (OPTIONAL)

_____ **Financial Responsibility**: I understand that I am financially responsible for any balance not paid by my insurance carrier. I understand that such balances will be due upon receipt of a statement from Tennessee GYN. I understand that a **late charge of $35** will be assessed on any balances **still due after 90 days** from the date of billing. I understand that any dispute in payment by my insurance company is my responsibility. If it becomes necessary to refer my account balance for collection, I understand that a 30% collection fee will be added to my account balance.

_____ **Appointment No Show/Cancellations**: Appointments that you do not show up for or you do not cancel with 24 hours notice will be charged a **$35 office fee**. Appointments scheduled less than 24 hours in advance are non-cancellable.

_____ **Release for Billing**: I authorize the release of any medical information necessary to process claims for medical services, as per HIPAA regulations. I request payments of medical benefits directly to Tennessee GYN.

_____ **Responsibility for Copayments**: I understand that co-payments are due at the time of service. If my insurance charges a co-payment on labs or other tests, I will pay those charges when billed.

_____ **Responsibility for Referrals**: I understand that if my insurance requires a referral from my primary Care Physician, it is my responsibility to obtain that referral prior to my visit in this office. I understand that failure to do so will result in my being responsible for full payment of that day's charges.

_____ **TennCare Program**: I acknowledge that Tennessee GYN does not participate in any TennCare program and claims will not be filed to any of these programs as primary or secondary insurance. I confirm that I do **NOT** have any active TennCare coverage.

_____ **Receipt of Patient Brochure (this document)**: I acknowledge that I have received a copy of the practice brochure and agree to abide by the policies listed.

Patient Name: _____

Patient Signature: _____ Date: _____

TENNESSEE GYN
SUSAN E WEBB M.D.

ANNUAL HEALTH HISTORY

Name: _____ DOB: _____ Age: _____

Primary Care Physician: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Drug Allergies: ❒ None Known ❒ Yes (please list drug names & reaction)

_____

_____

Current Medications: (please include drug name, strength, and frequency)

_____

_____

_____

Past Medical History: (check any that apply to you)

❒ Anxiety ❒ Asthma ❒ Blood clots in legs ❒ Bone problems ❒ Bowel problems ❒ Cancer ❒ Depression ❒ Diabetes

❒ Heart disease ❒ Heart murmur ❒ High blood pressure ❒ Kidney problems ❒ Skin problems ❒ Thyroid problems

Past Surgeries: ❒ None ❒ Yes: (please give surgery, date, and physician name)

_____

_____

Social History

Smoker: ❒ Never ❒ Past ❒ Current Vaping/E-cigs: ❒ Never ❒ Past ❒ Current
If yes: Packs per day: _____ Number of years: _____
Alcohol: ❒ Never ❒ Past ❒ Occasionally ❒ Regularly
If yes: Quantity: _____ Frequency: _____ Number of years: _____
Recreational Drugs: (Marijuana, Cocaine etc) ❒ Never ❒ Past ❒ Current
If yes: Drug: _____ Quantity: _____ Frequency: _____

Gynecological History

Number of pregnancies: _____ Number of living children: _____
Date of last menstrual period: _____
How many days do you bleed: _____ How many days between periods: _____
How heavy: ❒ Light ❒ Moderate ❒ Heavy
Do you have pain before your period: ❒ No ❒ Yes How many days before?_____
What do you currently use for birth control: ❒ Tubal Ligation ❒ IUD ❒ Nexplanon ❒ Depo ❒ Pills ❒ Ring ❒ Patch
❒ Condoms ❒ Withdrawal method ❒ Abstinence ❒ N/A (menopause/hysterectomy, etc)
Painful intercourse: ❒ No ❒ Yes
Menopause: ❒ No ❒ Yes If yes, age: _____
Do you have a history of STDs: ❒ No ❒ Yes If yes, please check:
❒ Chlamydia ❒ Gonorrhea ❒ Herpes ❒ Warts ❒ HIV ❒ Hepatitis ❒ Syphilis ❒ HPV
Date of last pap smear:_____
Have you ever had an abnormal pap: ❒ No ❒ Yes If yes, result: _____
Date of last mammogram:_____ Date of last colonoscopy:_____
Date of last Bone Mineral Density (DEXA)Scan:_____ Date of last cholesterol test:_____

Family History
Does anyone in your immediate family have a history of cancer: ❒ No ❒ Yes
If yes, type: ❒ Breast ❒ Bowel ❒ Ovarian ❒ Other: _____
Any other major medical problems in your immediate family: ❒ No ❒ Yes (please explain)

_____

REVIEW OF SYSTEMS

Are you experiencing problems with:

1. Eyes, ears, throat: ❒ No ❒ Yes
If yes, explain: _____

2. Thyroid: ❒ No ❒ Yes
If yes, explain:_____

3. Diabetes: ❒ No ❒ Yes
If yes, explain:_____

4. Heart, Vessels: ❒ No ❒ Yes
If yes, explain:_____

5. Lungs, Chest: ❒ No ❒ Yes
If yes, explain:_____

6. Stomach, Abdomen: ❒ No ❒ Yes
If yes, explain: _____

7. Kidneys, Bladder: ❒ No ❒ Yes
If yes, explain: _____

8. Breasts: ❒ No ❒ Yes
If yes, explain: _____

9. Genital Area: ❒ No ❒ Yes
If yes, explain: _____

10. Legs, Feet: ❒ No ❒ Yes
If yes, explain: _____

11. Arms, Hand: ❒ No ❒ Yes
If yes, explain: _____

12. Nerves: ❒ No ❒ Yes
If yes, explain: _____

13. Brain, Nervous System: ❒ No ❒ Yes
If yes, explain: _____

14. Sleep problems: ❒ No ❒ Yes
If yes, explain: _____

Did you fill out this form yourself? ❒ No ❒ Yes

Patient Signature:_____ Date:_____

Did you have help? ❒ No ❒ Yes
If yes, by whom? (name/relationship to patient) _____

Helper's signature:_____ Date:_____

Reviewed by:_____Date:_____