



Center for Pelvic Health

A Member of Saint Thomas Health Services

REGISTRATION FORM

(Please Print)

Today's date:			PCP:			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
(Former name):			Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:		Social Security no.:		Home phone no.: ()		
P.O. box:	City:		State:	ZIP Code:		
Occupation:		Employer:		Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other family members seen here:						
Email Address:			Is it permissible to send you newsletters or communicate by email?: <input type="checkbox"/> Yes <input type="checkbox"/> No			

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ()		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:		Employer phone no.: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance		<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Medicare	<input type="checkbox"/> Commercial HMO	<input type="checkbox"/> Commercial PPO	<input type="checkbox"/> Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Other	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Center for Pelvic Health or insurance company to release any information required to process my claims.				
_____ Patient/Guardian signature			_____ Date	



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New Patient Form

Preferred Day time phone: _____

Pharmacy name and number: _____

Marital Status: _____

Occupation: _____

Who do you live with: _____

Do you use tobacco? Yes No If yes, how many packs per day? _____

Drink alcohol? Yes No If yes, how often? _____

Use recreational drugs? Yes No

Who referred you to our office? _____

What brings you to the office today? _____

PAST MEDICAL HISTORY (Please answer all questions with YES or NO)

Asthma	Yes	No	Endometriosis	Yes	No	Blood Clots	Yes	No	Thyroid disease	Yes	No
High blood pressure	Yes	No	Anemia	Yes	No	Heart disease	Yes	No	Abnormal pap smears	Yes	No
Strokes	Yes	No	Back Injury	Yes	No	Cancer	Yes	No	Migraines	Yes	No
Diabetes	Yes	No	Kidney disease/ stones	Yes	No	Osteoporosis	Yes	No	Sexually transmitted infections	Yes	No

ADDITIONAL: _____

PAST SURGICAL HISTORY (Please list and give dates) _____

REVIEW OF SYSTEMS (Please answer all questions with YES or NO if you have experience these symptoms recently)

Constitutional

Weakness Yes No
 Chills Yes No
 Fever Yes No
 Weight change Yes No

Respiratory

Shortness of breath Yes No
 Coughing blood Yes No
 Wheezing Yes No
 Nose bleeds Yes No

Neurologic

Headaches Yes No
 Fainting spells Yes No
 Memory loss Yes No
 Numbness/ tingling Yes No

Eyes

Glasses/contacts Yes No
 Double vision Yes No
 Blurry vision Yes No

Cardiac

Chest pain Yes No
 Swelling Yes No
 Irregular heart beat Yes No

Skin

Rash Yes No
 Hair growth/loss Yes No
 Pigment changes Yes No

Psychiatric

Depression Yes No
 Mood changes Yes No
 Anxiety Yes No

Musculoskeletal

Joint pain Yes No
 Muscle weakness Yes No
 Unsteady gait Yes No

Endocrine

Heat/cold intolerant Yes No
 Excessive thirst Yes No
 Increased urination Yes No

Ear, Nose, Throat

Hearing change Yes No
 Sore throat Yes No
 Sinus pain Yes No

Gastrointestinal

Diarrhea Yes No
 Constipation Yes No
 Heartburn Yes No

Genitourinary

Frequent bladder infections Yes No
 Painful urination Yes No
 Blood in urine Yes No

Hematologic: Bleeding Yes No Bruising Yes No

List your medications, dose and how often you take them: _____

List your Allergies to medicines: _____

FAMILY HISTORY (Please answer all questions with YES or NO and list family member affected)

Asthma	Yes	No	Who? _____	Tuberculosis	Yes	No	Who? _____	High blood pressure	Yes	No	Who? _____
Heart disease	Yes	No	Who? _____	Strokes	Yes	No	Who? _____	Cancer	Yes	No	Who? _____
Diabetes	Yes	No	Who? _____	Kidney disease	Yes	No	Who? _____	Osteoporosis	Yes	No	Who? _____

ADDITIONAL: _____

Patient Signature: _____

Date: _____

MD/APN Signature: _____

Date: _____

I have reviewed this history and have confirmed it.



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Consent to Disclose Protected Health Information

By signing this authorization, I authorize Center for Pelvic Health to disclose protected health information to the following individual (s):

Name: _____ Relationship: _____

I understand that NO PROTECTED HEALTH INFORMATION (other than as outlined by the Health Insurance Portability and Accountability Act) can be released to anyone, including spouses, parents, other family members, significant others or friends without the authorization. I understand I have the right to revoke this authorization in writing at any time. However, any disclosure that occurred prior to the date of the revocation is not affected.

Please list daytime telephone number(s) at which you prefer to be reached:

Is it permissible to send you newsletters or communicate by email?

_____ Yes _____ No

Can we leave a message regarding your protected health information at the numbers you have provided above?

_____ Yes _____ No

Signature: _____ Date: _____

Printed Patient Name: _____ DOB: _____

NOTE TO MINORS AND PARENTS: The health information regarding contraception, sexually transmitted disease, HIV and certain other medical treatments of minors is protected. Therefore, in order for the Center for Pelvic Health to disclose any protected health information to the parent's, we must have written authorization from the minor patient. Minor patients should be aware that claims cannot be submitted to a parents' insurance company without disclosure of protected health information.



An Affiliate of Saint Thomas Health Services

Center for Pelvic Health
4601 Carothers Parkway, Suite 350
Franklin, TN 37067

Phone: 615-284-4664
Fax: 615-284-4668

Directions:

From South:

From I-65 North take exit #65 east (right) onto Hwy 96/Murfreesboro Rd. Go to 2nd traffic light and turn left (north) onto Carothers. *(This is the light next to Steak and Shake)* Travel down Carothers Parkway past the Williamson Medical Center Emergency Room entrance and parking garage. The Physicians Tower will be on the left side of the road. *(If you travel to Liberty Pike, you have gone too far.)* You may enter the parking lot from the side street next to the tower. Visitor parking is free in front of the Physicians Tower. Take elevators to third floor.

From North:

From I-65 South take exit #65 east (left) onto Hwy 96/Murfreesboro Rd. Go to 2nd traffic light and turn left (north) onto Carothers. *(This is the light next to Steak and Shake)* Travel down Carothers Parkway past the Williamson Medical Center Emergency Room entrance and parking garage. The Physicians Tower will be on the left side of the road. *(If you travel to Liberty Pike, you have gone too far.)* You may enter the parking lot from the side street next to the tower. Visitor parking is free in front of the Physicians Tower. Take elevators to third floor.

