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V 2.0

PATIENT HISTORY FORM (Please Print)

Office Use Only: ID:

Last Name:

First Name:

Primary Care Doctor:

Reason for visit: ☐ Annual ☐ Problem

MENSTRUAL HISTORY

Last Menstrual Period: ☐☐ / ☐☐ / ☐☐

Age at 1st Menstrual Period: ☐☐ # Days: ☐☐

Frequency: # Weeks: ☐ or Irregular: (check) ☐

Amount: (check) ☐ light ☐ normal ☐ heavy

Menopause: ☐

Method of Birth Control (check one)

☐ Abstinence ☐ DepoProvera ☐ Oral contraceptives

☐ Condoms ☐ Early Withdrawal ☐ Tubal Ligation/ Vasectomy

☐ Contraceptive Patch/ring ☐ IUD ☐ Other

☐ None

OBSTETRICAL HISTORY (List number of pregnancies)

☐ # Preterm Vag Deliveries ☐ # Preterm C-Sect Deliveries ☐ # Miscarriages

☐ # Full term Vag Deliveries ☐ # Full term C-Sect Deliveries ☐ # Elective Terminations

SURGICAL HISTORY Check all that apply:

☐ Appendectomy ☐ Gall Bladder ☐ Tonsillectomy

☐ D & C ☐ Hysterectomy ☐ Other

MEDICATIONS

☐ None ☐ Blood Pressure ☐ Hormones

☐ Anti-Depressant ☐ Diabetes ☐ Thyroid

☐ Contraceptive ☐ Heart ☐ Other

DRUG ALLERGIES

☐ None ☐ Penicillin ☐ Other

☐ Codeine ☐ Shellfish

SOCIAL HISTORY

Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Employed: ☐ Yes ☐ No

Cigarettes per day: ☐☐ (Check if Yes)

Substance Abuse ☐

Alcohol drinks per wk: ☐☐ Seatbelt use ☐

Exercise: ☐ Yes ☐ No Physical/Sexual Abuse ☐

MEDICAL/FAMILY HISTORY

Check problems you (P) or your family (F) have or had:

P	F		P	F	
☐	☐	Anemia	☐	☐	Kidney Stones
☐	☐	Arthritis	☐	☐	Hepatitis
☐	☐	Asthma	☐	☐	Lung Disease
☐	☐	Bladder Problems	☐	☐	Lupus
☐	☐	Clots in veins	☐	☐	Osteoporosis
☐	☐	Blood Transfusion	☐	☐	Reflux
☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Heart Disease	☐	☐	Thyroid
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	High Cholesterol	☐	☐	Breast Cancer
☐	☐	Intestinal Disease	☐	☐	Ovarian Cancer
☐	☐	Irritable Bowel Syndrome	☐	☐	Uterine Cancer
☐	☐	Kidney Disease	☐	☐	Colon Cancer
			☐	☐	Other Cancer

SEXUAL HISTORY

Age of first sexual Intercourse ☐ < 18 yrs old ☐ > 18 yrs old

# of sexual partners ☐ 3 or less ☐ 4 or more

Sexual activity: ☐ Never ☐ Females ☐ Males ☐ Both

GYNECOLOGIC HISTORY (Month/year)

Last pap smear: ☐☐ / ☐☐☐☐

Last Mammogram: ☐☐ / ☐☐☐☐

Check problems you have or had:

☐ Abnormal pap smears ☐ Infertility

☐ Endometriosis ☐ Painful Periods

☐ Fibroids ☐ Sexually Transmitted Diseases

CURRENT/PREVIOUS MEDICAL CONCERNS

(check all that apply; (C) Current (P) Previous)

C	P		C	P	
☐	☐	Weight change	☐	☐	Bleeding between periods
☐	☐	Fever/chills	☐	☐	Heavy vaginal bleeding
☐	☐	Difficulty sleeping	☐	☐	Vaginal discharge
☐	☐	Eyes	☐	☐	Low sex drive/ sexual dysfunction
☐	☐	Hearing loss	☐	☐	Recurrent yeast infections
☐	☐	Sinus congestion	☐	☐	Painful intercourse
☐	☐	Chest pain/palpitations	☐	☐	Pelvic pain
☐	☐	Cough/wheezing/ difficulty breathing	☐	☐	Skin rashes
☐	☐	Bloody sputum	☐	☐	Breast pain/discharge/mass
☐	☐	Nausea/vomitting	☐	☐	Seizures
☐	☐	Diarrhea	☐	☐	Fainting episodes
☐	☐	Constipation	☐	☐	Mood changes/depression/ Anxiety
☐	☐	Bloody stools	☐	☐	Heat/cold intolerance
☐	☐	Frequent urination	☐	☐	Excessive thirst or urination
☐	☐	Painful/blood urination	☐	☐	Hot flashes
☐	☐	Leakage of urine	☐	☐	Abnormal bruising/bleeding

X

Covenant Healthcare for Women

C. Brent Boles, MD, FACOG

Covenant Healthcare for Women, PLLC

I authorize the release of my Protected Health Information to the following listed individuals:

_____

_____

_____

_____

(If their name is not listed above, we are unable to discuss ANYTHING with the individual. Example-test results, appointments changes, or any medical information.)

_____ _____

Signature of Patient/ Legal Guardian Date

HIPAA Notice of Privacy Act is available upon request.

1800 Medical Center Pkwy., Suite 325 • Murfreesboro, TN 37129

615.867.0034 • Fax: 615.867.0717

C. Brent Boles, MD, FACOG

PATIENT INFORMATION: **Primary Care Physician:** _____

Patient's Name: _____

Street Address: _____City_____State/Zip_____

Home Phone (____) _____ Cell (____) _____ Alternate (____) _____

SSN_____ Race_____ Social Status_____DOB_____

Employer Name_____ Work Phone (____) _____

Spouse Name_____ Spouse DOB_____

Spouse Employer_____ Spouse Work (____)_____

In the event of an EMERGENCY contact:

Name: _____ Phone (____) _____ Relationship: _____

PHARMACY:

Name_____ Street_____ City_____ Phone (____) _____

BILLING INFORMATION: (Who will pay for services not covered by insurance?)

Name: _____ Phone: (____) _____Relationship: _____
Address: _____
DOB: _____ SSN: _____ Work (____) _____

INSURANCE:

PRIMARY: _____ SECONARY: _____
ID (Policy#): _____ ID (Policy #): _____
Insured Name: _____ Insured: _____
Insured DOB: _____ Insured DOB: _____
Insured SSN: _____Insured _____
Relationship to Pt.: SELF SPOUSE CHILD Relationship to Pt.: SELF SPOUSE CHILD

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly C. Brent Boles, MD, or Covenant Healthcare for Women, PLLC. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or dependent.

Patient Signature: (Or Legal Guardian if minor)

_____ Date _____

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FINANCIAL RESPONSIBILITY FORM

Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability. Not all insurance covers every service rendered. Some reasons for non-payment by insurance could include, but are not limited to 1) services not medically necessary as defined by your plan, 2) party financially responsible for plan may not have paid for coverage in a timely manner, 3) not eligible for benefits, 4) in some cases services are not pre-approved, 5) the services are excluded, or not covered by your plan of benefits.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is obtained by contacting your insurance carrier. We attempt to verify that your coverage is valid at the time of the visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for payment is yours.If you have had any changes in your insurance coverage – even if there is only a small change in the co-payment amount or a change in the expiration date of the policy – you must notify us. Even a small discrepancy on the claim form can lead to a claim denial. You are required to provide us with a copy of ANY insurance coverage that you have. Even if services rendered are not covered benefits of coverage you have, it still has to be filed with that company as well as your other insurance. If you have Private insurance as a primary and State issued coverage as a secondary, you must provide us with both, otherwise it is considered Insurance fraud and we are required to report this.

CO-PAYMENTS, CO-INSURANCES AND DEDUCTIBLES

Co-payments and co-insurances are your responsibility. Your insurance company expects us to collect them from you at the time of service. Understand that you will be expected to pay your co-payment for each and every date of service. You are also responsible for your deductibles. The deductible is determined by your individual contract with your insurance carrier. We do not have information about each person's deductible amount, and how much of that has been met. You will be responsible for finding out all information about your deductible prior to your appointment with our office.

NON-COVERED SERVICES

All patients are responsible if their insurance carrier denies payment for services rendered because they were "non-covered services." These non-covered services may include certain treatment types, blood work, supplies or equipment, etc. To avoid this, please check with your insurance carrier prior to receiving any treatment.

We appreciate a 24 hour notice to cancel, or reschedule your appointment. A $25.00 no show/no call cancel fee will be assessed if advance notice is not given.

I _____ (print) certify that I have read the above information. Any questions about this form have been discussed. My signature also certifies my understanding and agreement of the above policies. I understand that I am responsible for all charges not paid by my insurance company. A photocopy of this original document is as valid as the original.

You may receive a copy upon request.

Signature _____ Date _____
(Signature of pt. or financially responsible party)

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Covenant Healthcare for Women, PLLC
Policy for Insurance
(Patients with Americhoice and Amerigroup)

Patients that are insured with Americhoice, Amerigroup, or any other state issued medical insurance are required by law to provide documentation of any other medical insurance coverage that would serve as a primary insurance. Patients with a primary insurance that use Americhoice, Amerigroup, or other Tenncare insurance as a secondary are required to file with primary insurance before Tenncare, and then the remainder gets filed to Tenncare. Patients with a private primary insurance will usually not have to pay a co-pay with Tenncare coverage as a secondary.

Providing us with all insurance information is required by the state, as well as our office. Even if the primary insurance does not cover the services rendered, it has to be filed first with the primary coverage, and then filed again with Tenncare.

If a patient does not provide us with their primary insurance, and uses only the Tenncare coverage, then the state of Tennessee considers that insurance fraud. We are required to report this to the state if we discover that not all information has been given.

FOR PREGNANT PATIENTS: Have you been to DHS to apply, AND had the nessecary interview to obtain Tenncare Coverage?

Please circle one: **YES** **NO**

***If you are pregnant, and have only 45 days presumptive coverage from Tenncare, we can not see you today. You must go to DHS and apply, and then wait for the interview before we can schedule an appointment. We can not guarantee services will be paid with only presumptive coverage. The only services guaranteed to be covered with presumptive coverage are emergency services. Presumptive coverage only PRESUMES that you will be approved for Tenncare coverage, you must go to DHS (Dept. of Human Services, located on Old Fort Pkwy, behind Hobby Lobby) to apply, and wait to be approved ***

Signature : _____ Date : _____

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