Premier Women's Health Center
"Making a difference in women's lives!"
OBGYN offices of:

Bryan Myers, M.D., PC
Melody Harrison, NP-C
Courtney Murray, D.O., P.C.
Mary Beth McClain, APN

Ashley De Witt, D.O., PC
Michael Nobles, M.D., PC
Saharra Jewell, APN

Today's Date:_____

Patient's name:_____
Date of Birth:_____ Age:_____ Social Security #_____
Mailing Address or P.O. Box_____ City_____
State____Zip Code_____ Sex:_____ Home Phone:(___)_____ Cell:(___)_____
Workplace phone:_____ Marital Status:_____
Are you a student?Full time_____ Part time_____ Email_____
Employment_____ Job title_____
Employment status: Full time Part time Not Employed Self Employed Retired Military
Name of Spouse(If you are under 21 name of parent)_____
In case of emergency, who may we notify(other than spouse)?
Name_____ Relationship_____ Phone _____

Insurance Information

Do you have insurance?_____ Name of insurance_____
Subscriber name_____ SS#_____ Date of Birth_____
Your relationship to subscriber_____ Subscriber phone_____
Subscriber mailing address_____
Insurance ID# _____ Group #_____ Employer_____

Secondary insurance/Name of company_____
Subscriber name_____ SS#_____ Date of Birth_____
Your relationship to subscriber_____ Subscriber phone_____
Subscriber mailing address_____
Insurance ID# _____ Group #_____ Employer_____

Who is your primary physician ? _____ Phone_____
Who referred you to our office?_____
Who is responsible for this bill?_____

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I, the undersigned, certify and acknowledge the following:

- I authorize this office to release any health information for the use of treatment, payment, and healthcare operations which include insurance companies, specialists, and other healthcare providers and institutions.
- I am 18 years or older. If you are under 18, your parent or guardian must sign this form.
- I understand that diagnostic tests may be recommended and denial of these tests can result in undiagnosed and untreated health conditions.
- I understand that I am financially responsible for all charges not covered by insurance assignment.
- I assume responsibility for all costs of collections, including financial charge, attorney fees and court costs.
- I have checked and know that my insurance company covers Premier Women's Health Center as a provider in or out of network.
- I understand that medical treatment carries with it some statistical risks even when performed with the utmost care.
- I understand that all co-pays, deductible amounts, or self pay services are due at the time of service.
- I understand that appointment times are reserved specifically for me and that any necessary changes should be finalized two working days prior to the original appointment or a late cancellation fee may be charged.
- I acknowledge I received the Premier Women's Health center privacy notice attached to this form.
- I have accurately answered all the questions here and on the medical history form, and have read all the above information.
- I understand that it is necessary to bring all forms such as disability and FMLA forms in the office one week prior to the time that they are due. I understand that there is a 20.00 fee for these forms.

Signature_____ Date signed_____

Printed name_____

If personal representative signature appears above, please describe authority to do so

_____

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Privacy Practices Notice of Acknowledgment

Name:_____

Acknowledgment

_____I acknowledge that I have been offered the **Notice of Privacy Practices** but declined.

_____ I acknowledge that I have been offered the **Notice of Privacy Practices.**

I give my permission to speak to the following on any medical issue:

	Name
_____My spouse	_____
_____My child/children	_____
_____My caregiver	_____
_____Other	_____

Check all that apply.

_____I give my permission to leave messages on my answering machine or with anyone answering my personal phone.

_____ I give my permission to contact me at my place of employment. If I am unavailable, I give permission for a message to be left to return the call.

_____ I give my permission for my physician to fax any information regarding me to another physician's office that may be covering for my doctor, or a physician that I have been referred to.

_____ I give my permission for my pharmacy to be contacted regarding my medications. My pharmacy is___ _____(pharmacy/city).

I will notify this office in writing (verbal will not be accepted) if there is any change in my above permission.

_____ _____

Name Dat3

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Welcome! Please fill out all information to the best of your ability so that we may better serve you!

Medical History

Date: _____ My appointment is with: _____

Patient Name: _____ DOB: _____ Age: _____

Reason for your visit today: _____

Who is your primary care physician? _____

Current Medications: _____

What pharmacy do you use for prescriptions? _____

First day of last period: _____ Do you have regular monthly periods? Y / N

How often do your periods come? _____ Age at first period _____

Periods are: Mild Moderate Heavy Cramps are: Mild Moderate Severe

Drug Allergies: _____

Current birth control: _____

Age at first intercourse: _____ Number of partners (lifetime): _____

Are you having any libido changes? Y / N (please explain) _____

Do you have pain with intercourse? Y / N (please explain) _____

Have you ever had a sexually transmitted disease? Y / N (circle any that apply)

Gonorrhea Chlamydia Herpes Hepatitis B HIV Syphilis Genital Warts PID Trichomonas HPV

Do you use tobacco products? Y / N About _____ cigarettes per day

Do you drink alcohol? Y / N About _____ drinks per week

Are you experiencing any vaginal or urinary:

Discharge Odor Burning Itching Frequency Urgency Loss of Urine

Other: _____

Last Pap smear (month and year): _____ Results: _____

Have you ever had an abnormal pap smear? Y / N

If yes, please give year and any procedures _____

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Last Mammogram (month and year): _____ Results: _____

Have you ever had an abnormal mammogram? Y / N

If yes, please give year and any procedures _____

Do you do monthly breast exams? Y / N / Occasionally

Do you diet? Y / N What type? _____

Do you exercise? Y / N How often & how long? _____

Do you take Calcium? Y / N If so, how much? _____

Notes: _____

Please list all surgerics/hospitalizations

Surgery/reason for hospitalization	Date

Please list all pregnancies

Year	Method of delivery	Gestational age	Sex	Weight	Comments/complications

161 Shirley Drive, Winchester, TN 37398
931-962-0450 (ofc) - 931-962-0470 (fax)

1402 Willow Drive, Manchester, TN 37355
931-455-0247 (ofc) - 931-455-0470 (fax)

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Medical Problems

Date of Diagnosis	Medical Problem

Personal & Family History (mark all those that apply)

Disease	Self	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother/ Sister	Other
Alcoholism									
Anemia									
Arthritis									
Asthma/lung problems									
Blood clots									
Bloody stools/ colon polyp									
Cancer (note type of cancer in box)									
Diabetes									
Heart disease									
High cholesterol									
High blood pressure									
Kidney disease/UTIs									
Liver disease									
Mental illness									
Osteoporosis									
Seizures									
Stomach ulcers									
Stroke									
Thyroid disease									
Tuberculosis									
Other									

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Review of systems

Please indicate if you are having any current problems in the following areas by marking an X in the appropriate column.

General wellness	Y ___ N ___	Muscle/joints/bones	Y ___ N ___
Eyes	Y ___ N ___	Skin	Y ___ N ___
Ear, nose, throat	Y ___ N ___	Neurological	Y ___ N ___
Heart/circulation	Y ___ N ___	Psychiatric	Y ___ N ___
Lungs/breathing	Y ___ N ___	Endocrine	Y ___ N ___
Stomach/digestion	Y ___ N ___	Blood/lymph	Y ___ N ___
Reproduction/urinary	Y ___ N ___	Allergies	Y ___ N ___

Completed by: _____ **Signature:** _____ **Date:** _____

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