Please Complete ALL Information-Thank You

PLEASE USE ONLY DARK INK! (BLACK OR CARK BLUE)

Date: ____/_____/________

Physician: Micetich Boxell Williams
Referring Doctor/Person:________________________________

Patient's Last Name: _________________________ First Name: ______________________M.I:____
Permanent Address: ____
City: _________________________________ State: __________ Zip Code: _______________
SS #:______/_______/_________
Date of Birth: ______/_______/__________

Marital Status: ___ Single ___ Married __ Divorced __ Widowed

Home Phone #: (____) _______-___________ Work Phone #: (_____) _______-__________
Cell Phone #: (____) ______-____________ Email: _________________________@_________.______

May we contact you at work? ☐ Yes ☐ No
May we leave a message on your answering machine? ☐ Yes ☐ No

Emergency Contact(s) Information:

Name: ____
Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other:___________
Phone Number: (______) _______-_______________
Name: ____
Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other:___________
Phone Number: (______) _______-_______________

Employment Status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired ☐ Active Duty ☐ Unemployed

Student Status: ☐ Full-time ☐ Part-time ☐ Not a Student

- Primary Insurance Carrier (Name of Insurance): ____________________________

Subscriber's Name: ________________________ Date of Birth: _______/______/________
Subscriber's Employer: __________________________ SS #: ________/______/__________
Policy/ID Number: ____
Group/Account Number: ______________________________________

*((Please note that ALL information in the Insurance section MUST be completed to insure accurate and timely insurance filings. Failure to provide all necessary information could result in claims denial & larger patient monetary responsibility.))

- Secondary Insurance Carrier (Name of Insurance):__________________________

Subscriber's Name: ________________________ Date of Birth: _______/______/_________
Subscriber's Employer: __________________________ SS #: ________/______/__________
Policy/ID Number: ____
Group/Account Number: ______________________________ ☐ Not Applicable

Patient's Signature: ______________________________ **Date:** _______________

(ALL patients must sign)

Jackson Regional Women's Center

OB/GYN PATIENT HISTORY

Patient Name: ______________________________ Date of Birth: ______________
Social Security #: ______________________________ Date Form Completed: ______________

*IF YOU'RE UNCOMFORTABLE ANSWERING QUESTIONS, LEAVE THEM BLANK; YOU CAN DISCUSS THEM WITH YOUR DOCTOR OR NURSE.

Referring Physician: ______________________________ Phone #: ______________

*IF WE ARE UNABLE TO REACH YOU BY MESSAGE, REGARDING YOUR MEDICAL RECORD, WE CAN LEAVE A MESSAGE WITH ____________________ AT THE PHONE NUMBER ______________ .

PERSONAL HEALTH HISTORY

1. Are you allergic to any medications? ☐ Yes ☐ No
   If yes, please list: ______________________________
   ____
   ____

2. Please mark any condition that you have or have had in the past:
   - ☐ Cancer
   - ☐ HIV/AIDS
   - ☐ Diabetes
   - ☐ Epilepsy
   - ☐ Thyroid Disorder
   - ☐ Eating Disorder
   - ☐ Heart Disease
   - ☐ Headaches
   - ☐ Depression
   - ☐ High Blood Pressure
   - ☐ Arthritis or Lupus
   - ☐ Asthma
   - ☐ Kidney Disease
   - ☐ Frequent Infections
   - ☐ Anemia
   - ☐ Hepatitis
   - ☐ Herpes
   - ☐ Bowel Disease
   - ☐ Von Willebrands (e.g:phlebitis)
   - ☐ Recurrent Urinary Tract Infection

   Describe, if needed: ______________________________
   ____
   ____

3. Please indicate any surgeries or hospitalizations that you have had: ______________
   ____
   ____
   ____

4. Do you or any family member have a history of problems with anesthesia? ☐ Yes ☐ No
   If yes, please describe: ______________________________
   ____
   ____

5. Do you have any religious objections to any form of medical treatment (Ex: Jehovah's Witness, refusal of blood transfusion)? ☐ Yes ☐ No
   If yes, please describe: ______________________________
   ____
   ____

Jackson Regional Women's Center

REVIEW YOUR PREGNANCY HISTORY

1. List the number of times you have been pregnant ____________
2. List the number of times you have delivered ____________
3. List how many c-sections you have had ____________
4. List the number of times you lost the pregnancy (including miscarriage, elective abortion, tubal pregnancy, etc) ____________
5. Did you have diabetes in your pregnancy? ☐ Yes ☐ No

EXPOSURE AFFECTING HEALTH

1. Do you smoke Cigarettes? ☐ Yes ☐ No If yes, how many packs a day? ______
   If you are a former smoker, when did you quit? ____________
2. Do you drink alcoholic beverages before you became pregnant? ______
3. Do you drink alcoholic beverages now? ______
   (1.5 oz spirits = 12 oz beer) If yes, how often? ____________
   What type of drinks? ____________
4. Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, any herbal medicines, and their dosage: ____________

5. Please list any illicit or recreational drugs used since your last period (e.g: cocaine, marijuana, LSD, heroin, crack, etc): ____________

6. Do you have any reason to believe you may have been exposed to AIDS (e.g: history of blood transfusion, intravenous drug use, multiple sexual partners or sexual partner to a gay or bisexual male, exposure to an intravenous drug user)? ☐ Yes ☐ No
   If yes, please describe: ____________

7. Are you being exposed to chemicals or radiation (e.g: X-Rays)? ☐ Yes ☐ No
   If yes, please describe: ____________

Jackson Regional Women's Center

GYNECOLOGIC HEALTH HISTORY

- Last Menstrual Period ____________ Type of Birth Control ____________
- Do you perform monthly self-breast exams? ☐ Yes ☐ No
- When was your LAST Pap smear test? ____________
- Have you ever had an abnormal Pap test? ☐ Yes ☐ No
  If yes, when were you treated? ____________
  How were you treated? ____________
  What was the diagnosis? ____________
- Have you ever had: ☐ Gonorrhea ☐ Chlamydia ☐ Pelvic Inflammatory Disease
  If yes, when? ____________ How? ____________
  Where were you treated? ____________
  What was the diagnosis? ____________
- Have you ever had Herpes? ____________ ☐ Yes ☐ No
  If yes, how often do you have outbreaks? ____________
- Have you ever had Syphilis? ____________ ☐ Yes ☐ No
  If yes, when? ____________ How? ____________
  Where were you treated? ____________
- Have you ever used an IUD (intrauterine device) for contraception? ☐ Yes ☐ No
  If yes, please describe when ____________
  What treatment was received: ____________

FAMILY HISTORY & GENETIC SCREENING

1. What is your race? ____________ What's the race of the baby's father? ____________
2. What is the name of the baby's father? ____________
3. What is your marital status to the baby's father? ____________
4. Have you or the baby's father had a child born with a birth defect? ☐ Yes ☐ No
   If yes, please describe: ____________
   ____
5. Did you or the baby's father have a birth defect? ☐ Yes ☐ No
   If yes, please describe: ____________
   ____
6. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (e.g: mental retardation, birth defects, early infant death, deformities, or inherited diseases such as: hemophilia, muscular dystrophy or cystic fibrosis):
   Birth Defect ☐ Yes ☐ No Early Infant Death ☐ Yes ☐ No
   Deformities ☐ Yes ☐ No
   Neural Tube Defects:
   Anenocephaly ☐ Yes ☐ No Spina-bifida ☐ Yes ☐ No
   Any other genetic/chromosomal abnormalities not listed above: ☐ Yes ☐ No
   Please specify: ____________
   ____
   How is this child/person related to you? ____________

Jackson Regional Women's Center

PERSONAL AND FAMILY HISTORY

(Check all that apply in each category)

Cardiovascular	Patient	Family/Relationship	**Renal Disease**	Patient	Family/Relationship
Heart Disease			Cystitis		
Rheumatic Fever			Pyelonephritis		
Mitral Valve Prolapse			Asympotomatic Bacteruria		
Chronic Hypertension			Chronic Renal Disease		
Varicosities Thrombophlebitis			Neurologic Disorder		
Previous Pulmonary Embolism			Autoimmune Disease		
Blood Disorders			Cancer		
Anemia			Hemoglobinopathy		
Blood Transfusions			Seizure Disorder		

Other: ____________________

Pulmonary	**Patient**	**Family/Relationship**	**Other**	**Patient**	**Family/Relationship**
Asthma			Psychiatric Disease		
Tuberculosis			Physical Abuse/Neglect		
Chronic Obstructive Pulmonary Disease			Emotional Abuse/Neglect-Addiction (Drug, Alcohol, Nicotine)		

Other: ____________________

Endocrine	**Patient**	**Family/Relationship**	**Other**	**Patient**	**Family/Relationship**
Diabetes			Major Accidents		
Thyroid Dysfunction			Surgery		
Maternal PKU Endocrinopathy			Anesthetic Complications		
Gastrointestinal			Non-Surgical Hospitalization		
Liver Disease			No Known Disease/Problems		

Other: ____________________

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Genetic History	Patient	Family/Relationship	Other	Patient	Family/Relationship
Age>35(Female)>50 (Male)			Mental Retardation		
Cerebral Palsy			Muscular Dystrophy		
Cleft Lip			Cleft Palate		
Congenital Heart Disease			Sickle Cell Disease/Trait		
Congenital Anomalies			Tay-Sachs Disease		
Consanguinity			Test for Fragile X		
Cystic Fibrosis			Thalassemia A or B		
Down Syndrome			Hemophilia		
Huntingdon's Chorea			Neural Tube Defect		

Other: ____

7. Do you or the baby's father's family have a personal or family history of pregnancy losses (miscarriages, stillbirths)? ______________
   If yes, have either of you had genetic counseling? ☐ Yes ☐ No
   If yes, have either of you had a chromosomal test? ☐ Yes ☐ No
   What were the results? ______________________________________
   Where were the results?______________________________________

8. Some genetic problems occur in more couples with certain racial or ancestral backgrounds. Please check if you or the baby's father are in one of these backgrounds:
   - Eastern European Jewish (Ashkenazi) ancestry ☐ Yes ☐ No
     If yes, have you had the Tay-Sachs screening test? ☐ Yes ☐ No
     If yes, have you had a Canavan screening test? ☐ Yes ☐ No
     If yes, have you had a Cystic Fibrosis screening? ☐ Yes ☐ No
     If yes, have you had a Familial Dysutonomia screening? ☐ Yes ☐ No
     Date: ______________ Result: ______________________________
   - African American ☐ Yes ☐ No
     If yes, have you had the Sickle Cell screening? ☐ Yes ☐ No
     Date: ______________ Result: ______________________________
   - European Ancestry & Eastern European (Ashkenazi) ancestry ☐ Yes ☐ No
     If yes, have you had a Cystic Fibrosis screening? ☐ Yes ☐ No
   - Mediterranean ancestry or Southwest Asian ancestry? ☐ Yes ☐ No
     If yes, have you had the screening for inherited forms of anemia, such as, Thalassemia? ☐ Yes ☐ No

9. Please list any other concerns you have about birth defects or inherited disorders:

____

____

10. Do you want to have a Down Syndrome Risk Assessment? ☐ Yes ☐ No
11. Is the father 50 years or older? ☐ Yes ☐ No

PSYCHOSOCIAL SCREENING

1. Do you feel safe where you live? ☐ Yes ☐ No
2. Are you exposed to second-hand smoke? ☐ Yes ☐ No
3. In the past 2 months, have you used drugs or alcohol? ☐ Yes ☐ No
   (including beer, wine, or mixed drinks)
4. Have you moved in the past 12 months? ______________________
   How many times? __________

____
Print Name

____
Patient Signature

____
Date

ATTENTION

- Any patients that are being seen for a problem, pregnancy, or transferring from another doctor, please make sure you have your records BEFORE your appointment. **For better assurance, it is best you call the week before to check if your records have been received.**
- You may also pick the records up and bring them with you to your appointment.
- If you fail to have your records faxed, mailed, or brought at the time of your appointment, **YOU WILL BE ASKED TO RESCHEDULE**. It is very important that our doctors have these records at your first appointment.
- If you have any questions, call our office at (731) 668-4455.
- Our fax numbers are (731) 668-9007 or (731) 664-4508.

Advance Directives

Do you have a living will? ☐ Yes ☐ No

Do you have a Tennessee durable Power of Attorney for Healthcare?
☐ Yes ☐ No

IF THE ANSWER TO THE ABOVE QUESTION(S) IS/ARE YES, PLEASE PROVIDE US WITH A COPY OF EACH DOCUMENT YOU HAVE FOR YOUR HEALTH VARE RECORD.

What is an Advance Directive you may ask?

⇨ An Advance Directive is a document written before a disabling illness. It states a patient's choices about treatment. It may name someone to make choices on your behalf if you are unable. With these Advance Directives, you are able to legally decide about your future medical treatment.

⇨ Two types of Advance Directives are allowed by Tennessee law. They are a living will and a Durable Power of Attorney for Healthcare. For more information, please contact a family member or your family's legal counsel.

⇨ If you do NOT have one or both of these Advance Directives, it will not affect your ability to receive care from us. It is our legal obligation by Tennessee State Law to inform our patients of these options.

Thank you for allowing us to take care of your healthcare needs.

Authorization for Insurance Payment-JRWC Policy

It is a courtesy for our office to file insurance claims though the patient/guardian is still responsible for all charges incurred if payment by insurance is denied. You will still be responsible for any co-pay and/or percentage, for which the insurance carrier is not liable at the time services are rendered. In the event that your insurance carrier has not remitted payment to us within 45 days of the date of claim receipt, the entire account balance becomes the patient/guardian's responsibility.
It is solely the patient's responsibility to obtain prior to their appointment any referrals required of them by their insurance carrier or you will be liable on the date of services for all charges incurred. If we are unable to obtain satisfactory payment from the patient within a reasonable amount of time, your account will be placed with a collection agency for aggressive collection action. At that time, you will be held liable not only for the account balance but also for any costs associated with the collection agency's involvement.

I, ____, do hereby authorize the physicians at JRWC to administer treatment as they deem advisable for my diagnosis and/or treatment. I certify that I have been made aware of the role and services offered by the physicians, nurse practitioner, and nurses at JRWC and consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

____ ____________________

Patient/Guardian Signature Date

____

Witness

Medical/Medigap Lifetime Authorization

HIC # _______________ (Medicare ID number) ***ONLY Medicare Patients Sign***

*I certify that the information given to me in applying for payment under Title XVII of the Social Security Administrative Act is correct. I hereby authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers of any information deemed necessary for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf; I assign the benefits payable for physician services to the physician or organization furnishing the services.

____ ____________________

Patient/Guardian Signature Date

____ ____________________

Printed Name Relationship to Patient

____ ____________________

Witnessed By Address

Reason Patient is unable to sign:

____

Clinical Financial Policies

The JRWC accepts insurance from most major insurance companies. However, please remember that insurance is a contract between you and the carrier. As a courtesy to our patient, we will review patient's insurance coverage, estimate insurance company coverage and file claims with patient's insurance carriers. The patient is required however to assign all insurance company payments directly to the practice to avoid and misunderstandings regarding payment for professional services rendered. The patient or guardian will be held responsible for any charges not covered or denials by their insurance company. We will work with you in every way possible to maximize your insurance benefits.

If the patient is unwilling to assign payments, all services provided will be billed as self-pay at the time of each visit.

All Obstetrical and surgery and patients will be required to establish a written Financial Agreement for payment at the time of the services rendered. The patient will be notified when the payment has been remitted by their carrier for outstanding claims via their account statement. The Insurance Billing Specialist will apply those payments to the patient's account and refund any credit balances the calendar month following payments from the carrier.

By law, the insurance carriers must remit payment or deny the claim within 30 days of initial notice of the claim. If any insurance problem arises while trying to process your claim, JRWC will ask the patient to assist in resolving said issue to maximize payment. The JRWC firmly believes that a good physician/patient relationship effort to clarify any misunderstandings or concerns in regard to account balance and payments.

All patient accounts are due and payable within 30 days of services rendered unless payment plan has been arranged at the time services were rendered. Each month you will receive a statement for any balance due with payment expected within 30 days. If your payment is not received in a timely manner, our staff will mail a reminder notice indicating there is a problem with your account and you will need to contact us. If the payment of account charges is not remitted in full after 90 days of notice, without pending insurance claims or financial arrangements, all future credit with us will be limited until balance is paid in full.

All patients are required to pay any co-pay and/or deductible necessary at the time of service. If you have any questions regarding the financial policy, please ask to speak with the JRWC's Practice Manager.

I have read and understand the JRWC's financial policies and do hereby agree to accept them.

______________________________________ ________________________

Patient/Guardian Signature Date

Jackson Regional Women's Center

Authorization to Release Protected Health Information

I ____ give my authorization to release protected health information to ____________________________________ who's relationship to me is ______________________________, if I am unable / unavailable to receive this information concerning my medical record. If there are any other people you would like to authorize, please place their name and relationship on the following lines:

Name: __________________________________ *Relationship:* ________________________

Name: __________________________________ *Relationship:* ________________________

______________________________________ ______________________

Printed Name (Patient) *Date*

____

Patients Signature

***I do **NOT** wish to assign anyone other than myself to receive information pertaining to my medical record.*

______________________________ _________________

Patient's Signature *Date*

Appointment Scheduling Guidelines

Our office strives to provide appointments in a timely manner. As a new patient we ask that you arrive at the clinic a minimum of 30 minutes prior to your scheduled appointment time in order to give you ample time to complete your registration paperwork and to get copies of your insurance cards.

As an established patient you must be no more than 15 minutes late for your scheduled appointment or you will be asked to reschedule. This could result in a several day or weeks wait for you. The exception to this policy is if JRWC's staff has been notified prior to clinic and is approved by the physician. However with that, the maximum time allowed is 30 minutes past your scheduled time.

You MUST be on time for your appointment if you are scheduled for an office surgical procedure or diagnostic test. No tolerance can or will be given unless specific instructions documented in your medical record have been given to you by JRWC staff or physician.

With any new or established patient, if the need arises to cancel your scheduled appointment, please notify the clinic staff at least 24 hours prior to your appointment time. The JRWC staff will work with you to set a new appointment date and time as soon as possible. Failure in giving at least 24 hours notice not only affects the entire doctor's schedule, but also can result in a $25 office fee being assessed to you personally for a missed/no notification appointment.

If you NO SHOW 3 **consecutive** appointments with JRWC, you will be terminated from the practice, sent a certified letter detailing the action, and have a copy of said letter sent to your insurance carrier. If you have any questions regarding these guidelines, please ask to speak with the JRWC Office Manager.

I have read and understand the JRWC's appointment policies and do hereby agree to accept them.

__________________________________ ________________________

Patient/Guardian Signature Date

Policy and Procedure for Completion of Patient FMLA forms & Insurance Forms

(ALL PATIENTS MUST SIGN THIS FORM STATING YOU ARE AWARE OF THIS POLICY)

Completion of these forms is a service provided by the JRWC for a minimal fee. We will be happy to complete single sheet forms at no charge; however, a $20 charge will be assessed if there are two or more pages to be completed. There will also be an additional $20 charge to make corrections on forms that may have errors that were not due to error on our part. Please be prepared to pay the fee for these forms when you present them to the clinic for completion. If you are unable to pay the fee, the forms will not be completed and will be returned until the fee is collected.

PLEASE ALLOW 7-10 BUSINESS DAYS FOR COMPLETION OF THESE FORMS

**I have read and understand the JRWC's form completion policies and do hereby agree to accept them.

____________________________________ __________________

Patient/Guardian Signature **(ALL PATIENTS MUST SIGN)** Date