

Dear New Patient,

Thank you for choosing Women's Care Group for your GYN care. This letter is to share some information with you that will help you prepare for your visit to our office.

Patient Information Sheets:

Please take a few moments to fill out the enclosed information sheets in **black ink only and bring them, completed**, to our office the day of your appointment.

What to expect on your first visit:

The nature of any problem you may have will determine the extent of the initial examination.

Office Information:

Our office hours are Monday – Friday 8:00 AM to 5:00 PM and we are closed weekends and holidays. Our practice is affiliated with UT Medical Center and Baptist West Hospital.

Information to bring on your first visit:

Please bring your current insurance card, a detailed list of current medications, and this notice. These three items will expedite your office encounter.

Blood Transfusion

In case of emergency if you are not willing to accept a blood transfusion please call our office before your appointment.

We would appreciate a 24-hour notice of cancellation if you find you are unable to come for your appointment. To cancel, please call (865) 546-1642.

**Women's Care Group Knoxville / Maryville
CONFIDENTIAL NEW PATIENT REGISTRATION**

***Copies of your insurance cards must be presented and will be copied and verified
A copy of your driver's license is required***

PATIENT INFORMATION

Name: _____ Social Security#: _____

Address: _____ Race: _____

Home Phone #: _____

City, State, Zip _____ Cell Phone#: _____

Referring MD: _____ Date of Birth: _____

Primary Care MD: _____ Age: _____

Marital Status [] Married [] Single [] Widowed

PATIENT EMPLOYMENT

Employer Name: _____ Phone: _____

SPOUSE'S INFORMATION

Name: _____ Social Security#: _____

Employer Name: _____ Date of Birth: _____

EMERGENCY CONTACT(S)

Name: _____ Phone#: _____

Name: _____ Phone#: _____

How did you hear about us? ____ Family ____ Friend ____ Church ____ Word of Mouth

____ Yellow Pages Ad ____ MD Referral ____ Other

Would you like information regarding a living will or Power of Attorney? ____ Yes ____ No

Signature: _____ Date: _____



LISTENING TO YOU. CARING FOR YOU. CLOSE TO YOU.

Patient Disclosure and Agreement

Name: _____ Today's Date _____

Your insurance contract will not cover more than one of the following visits per day. These visits cannot be combined. If you have more than one of the following we will be happy to schedule an appointment specifically for that reason for another day. This also helps our office respect your time and other patient's time by staying on schedule.

BLOOD TRANSFUSION

Please circle Yes or No:

YES NO In case of emergency I am willing to accept a blood transfusion.

Indicate only one of the following:

_____ **Annual Gynecologic Examination** (breast and pelvic exams, Pap smear, prescription refills)

_____ **Problem Visit and Examination** (bleeding problems, infections, pain, hormonal problems, menopause, surgery scheduling, contraception counseling, etc.)

_____ **Consultation for a Second Opinion or Consultation from a referring physician.**

If you are scheduled for the following, please indicate which one(s). Insurance contracts allow these tests to be performed on the same day as one of the above visits or on a separate day.

_____ **Lab Tests** _____ **Bone Density (DEXA)** _____ **Pelvic Ultrasound**

_____ **Urodynamics** _____ **Pregnancy Nonstress Test**

Indicate what your insurance contract covers:

_____ **My insurance contract covers annual gynecologic examinations.**

_____ **My insurance contract covers problem visits by a gynecological specialist.**

_____ **My insurance contract covers consultations by gynecological specialist.**

_____ **My insurance contract covers diagnostic tests.**

_____ **I do not know what my plan covers, but I want to be seen for the above indication anyway.**

_____ **I know I may be responsible financially for these expenses.**

Patient/Responsible Person's Signature: _____



LISTENING TO YOU. CARING FOR YOU. CLOSE TO YOU.

Acknowledgement of Notice of Privacy Practices

I have been given the opportunity to review the Notice of Privacy Practices and understand that the Notice describes how my protected medical information may be used and disclosed and how I may get access to this information. I have also been given the opportunity to take a copy of the Notice of Privacy Practices for further review.

If for some reason the facility needs to relay my protected health information, i.e. lab results or billing issues, you can either leave or discuss the information with the following individual(s):

1. _____
2. _____
3. _____
4. _____
5. _____

By signing below, I agree to the fore mentioned statements.

Patient or Guardian

Date

(If Guardian, relationship to patient)

Patient Name

DOB

Account Number/Chart Number



LISTENING TO YOU. CARING FOR YOU. CLOSE TO YOU.

PATIENT AUTHORIZATION

Patient Name: _____

Account #: _____

Date: _____

Regardless of your insurance coverage, you as the patient are always responsible for the payment of your charges. Unless you have Medicare, or an HMO, or a PPO membership office charges are to be paid by cash, check or credit card at the time of service. Counselors are available to discuss large dollar charges and payment schedules.

Authorization & Assignment:

I authorize WCG to release any information acquired by my physician/or staff to my insurance carrier(s). I authorize payments directly to my physician. I recognize and accept responsibility for any balance or fees not covered by insurance and agree to pay the balance in a prompt manner. In any event this account is referred to an outside agency, credit reporting bureau or attorney for collection, I agree to pay all attorney fees, collection costs, court costs and/or any other expenses incurred in its collection, according to the 1989 statues of the State of Tennessee.

Signature: _____

WOMEN'S CARE GROUP

LISTENING TO YOU. CARING FOR YOU. CLOSE TO YOU.

The Caring Doctors of Women's Care Group:

Pleas R. Copas, M.D., FACOG
Stephanie B. Cross, M.D., FACOG
Susan P. Dodd, M.D., FACOG
Kathryn Paige Kessler, M.D.
Steve A. McLees, M.D., FACOG
James O Shirk, M.D., FACOG
Sudha R. Nair, MD

Our Nurse Practitioners:

Susan Houchins, RNC, MSN, NP
Ramona G. Scott, WHNP, Registered Sonographer

Offering Extraordinary Personalized Care

Gynecologic Services Include:

- Annual pelvic exams & pap smears
- Breast exams & counseling
- Contraception
- Solutions to pelvic pain, abnormal bleeding & incontinence, including, laparoscopy & pelvic floor reconstruction
- Menopause counseling & hormone therapy for menopausal women
- DEXA Scans

Obstetric Services Include:

- Complete maternity care & delivery, including infant intensive-care services
- Certified American Institute of Ultrasound in Medicine; abdominal & vaginal sonograms
- Fetal Monitoring
- VBAC (vaginal birth after caesarean)
- Tubal Ligation

Infertility Evaluation and Treatment Services are Also Available

Two Convenient Locations
*University Medical Center (UT Hospital) & Baptist West
Hospital (Turkey Creek)*

Visit Our Website
www.wc-grp.com

Call for Your Appointment
(865) 546-1642

Directions to our offices

Women's Care Group-UT Office

1932 Alcoa Highway #150
Knoxville, TN 37920

Phone: (865) 546-1642

Directions: From I - 40 take the Great Smokey Mountains Exit (386B). Travel Highway 129 (Alcoa Highway) approximately 2 miles to the Cherokee Trail / UT Medical Center exit. Follow the exit. As you approach the hospital, notice the parking garage on the right side. Turn next to the parking garage following the signs to Physician Offices (the signs are yellow) and circle around. Park in the garage (any level provides parking for our office). Take the elevator to the 1st floor. We are in POB C, Suite 150. As you exit the elevator bay area, turn left. Continue straight, past the reception area. Our office is on the right side of the hall. **Do Not** go across the crosswalk.

Women's Care Group-Baptist West Office

Suite 108, Baptist Physician's Plaza
10810 Parkside Dr.
Knoxville, TN 37922

Phone: (865) 546-1642

Directions: Travel I-40 west to exit 374, Lovell Road. Turn left onto Lovell Road. Turn right onto Parkside Drive. At the red light, turn left into the Baptist West Hospital parking lot. The entrance will split by the fountain. Turn left at the split, and go into the main entrance.

Turn to the right beside the reception desk. You will come to the elevator bay area. Take the elevator to the first floor. Upon exiting the elevator, turn left and proceed through the double doors. Our office is immediately on the right.

Patient History Form

Name: _____
 DOB: _____

Menstrual History

If menopausal or had hysterectomy <input type="checkbox"/> Skip to next section Date of last menstrual Period _____ Were you taking oral contraceptive at the time? <input type="radio"/> Yes <input type="radio"/> No If applicable date of Preg. Test _____	Changes in period: <input type="radio"/> No Change <input type="radio"/> Shorter time between periods <input type="radio"/> Longer time between periods <input type="radio"/> Heavy bleeding with cycles	Symptoms/Problems with Menstrual Cycles: <input type="radio"/> Breast Tenderness <input type="radio"/> Cramps <input type="radio"/> Depression <input type="radio"/> Headaches <input type="radio"/> Misses school/work
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Contraception Skip this section if: ___ Not Sexually Active ___ Menopausal ___ Hysterectomy

Current Birth Control Method: <input type="radio"/> None <input type="radio"/> Condoms <input type="radio"/> Diaphragm <input type="radio"/> Rhythm/Withdrawal <input type="radio"/> Tubal Sterilization <input type="radio"/> Vasectomy <input type="radio"/> Essure <input type="radio"/> Birth Control Pills <input type="radio"/> Depo-Provera <input type="radio"/> Birth Control Patch <input type="radio"/> Vaginal Ring <input type="radio"/> IUD <input type="radio"/> Norplant <input type="radio"/> Contraceptive Foam	Satisfied with current Method <input type="radio"/> Yes <input type="radio"/> No Problems/Concerns with Current Method <input type="radio"/> None <input type="radio"/> Irregular bleeding <input type="radio"/> Headache
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Pap Smear History

Have you had a PAP smear? <input type="radio"/> Never (Skip to next section) <input type="radio"/> Had prior PAP(s) Approximate date last PAP _____ Prior Abnormal PAP(s) <input type="radio"/> None (Skip to Surgical History) <input type="radio"/> 1 _____ Date of last abnormal PAP <input type="radio"/> > 2 _____ Last abnormal PAP result: <input type="radio"/> Unsure <input type="radio"/> Atypia <input type="radio"/> Dysplasia/Cin <input type="radio"/> Carcinoma in situ <input type="radio"/> Warts/HPV	Test/Treatment after PAP: ✓ all that apply <input type="radio"/> No further treatments <input type="radio"/> Cervical Cone/LEEP <input type="radio"/> Cryotherapy (Freezing) <input type="radio"/> Laser Treatment <input type="radio"/> Hysterectomy <input type="radio"/> Other <input type="radio"/> No further treatment <input type="radio"/> Cervical Cone/LEEP <input type="radio"/> Cryotherapy (Freezing) <input type="radio"/> Laser Treatment <input type="radio"/> Hysterectomy <input type="radio"/> Other	Biopsy Results: <input type="radio"/> Unsure <input type="radio"/> Low Grade/Mild dysplasia <input type="radio"/> High grade/Moderate to severe dysplasia <input type="radio"/> CIS (Carcinoma in situ) <input type="radio"/> Invasive Cervical Cancer	Did PAPs revert to Normal? <input type="radio"/> Yes <input type="radio"/> No
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Surgical History Had Prior Surgery ___ Yes ___ No (If no go to next page)

<input type="radio"/> Abdominoplasty <input type="radio"/> Angioplasty <input type="radio"/> Appendectomy <input type="radio"/> Gastric bypass <input type="radio"/> Bladder Repair (Abdominal) <input type="radio"/> Bladder Repair (Vaginal) <input type="radio"/> Bowel Surgery <input type="radio"/> Breast Enlargement <input type="radio"/> Breast Biopsy <input type="radio"/> C-Section <input type="radio"/> Heart Bypass <input type="radio"/> Heart Valve Replacement	<input type="radio"/> Gallbladder Removal <input type="radio"/> Colon Removal (Partial or Complete) <input type="radio"/> Cone Biopsy of Cervix <input type="radio"/> D & C <input type="radio"/> Endometriosis Removal <input type="radio"/> Endometrial Ablation <input type="radio"/> Hernia Repair <input type="radio"/> Hip Replacement <input type="radio"/> Hysterectomy – Uterus Only <input type="radio"/> Hysterectomy – Uterus & Cervix <input type="radio"/> Hysteroscopy <input type="radio"/> Kidney Stone Removal	<input type="radio"/> Knee Replacement <input type="radio"/> Laparoscopy <input type="radio"/> Laser/Cryosurgery of Cervix <input type="radio"/> LEEP of Cervix <input type="radio"/> Mastectomy ___ Right ___ Left <input type="radio"/> Myomectomy <input type="radio"/> Ovarian Cyst Removal ___ Right ___ Left <input type="radio"/> Small Bowel Resection <input type="radio"/> Tonsillectomy <input type="radio"/> Tubal Ligation <input type="radio"/> Endometrial Ablation <input type="radio"/> Pelvic Prolapse Repair Surgery
<input type="radio"/> Other _____ _____		

Medical History (Check all that apply)

General <input type="checkbox"/> Anorexia <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer _____ Type <input type="checkbox"/> Obesity		<input type="checkbox"/> Diabetes <input type="checkbox"/> Lupus	Menopausal (Skip if N/A) Age at menopause _____ Yrs old HRT: Never taken _____ <input type="checkbox"/> Currently taking How long? _____ Months <input type="checkbox"/> Previously Taken _____ Years Previous bone density test <input type="checkbox"/> Yes Result: <input type="checkbox"/> Unsure <input type="checkbox"/> Normal <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> No Date of last bone density <input type="text"/>		
Cardiovascular <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke <input type="checkbox"/> Blood clots (Legs/Lungs) <input type="checkbox"/> Stroke		<input type="checkbox"/> Irregular Heart Rate <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Hypertension <input type="checkbox"/> Hyperlipidema			
Lungs <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Lung cancer <input type="checkbox"/> Rheumatic fever	Urinary <input type="checkbox"/> Fistula <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Kidney/Bladder cancer <input type="checkbox"/> Recurrent bladder infections <input type="checkbox"/> Leaking urine		
Gastrointestinal <input type="checkbox"/> Diverticulitis/Diverticulosis <input type="checkbox"/> Colon Polyps <input type="checkbox"/> Gastric Reflux <input type="checkbox"/> Ulcers <input type="checkbox"/> Liver disease <input type="checkbox"/> Crohns <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> IBS (Irritable Bowel Syndrome) <input type="checkbox"/> Pancreatitis Screening Tests: <input type="checkbox"/> Never had one <input type="checkbox"/> Barium enema <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Sigmoidoscopy <input type="checkbox"/> Stool screening		WHEN <input type="text"/>	Pregnancy (override preg. details – floaters) _____ Number of pregnancies _____ Number of live births _____ Number of miscarriages _____ Number of elective abort. _____ Number of ectopics Breast: Had a mammogram <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal mammogram or breast exam ____ Yes ____ No – Skip the outcome and findings section below		
		Outcome: <input type="checkbox"/> Reassurance <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Repeat mammogram <input type="checkbox"/> USG or MPI <input type="checkbox"/> Other _____	Finding if biopsy done: <input type="checkbox"/> Benign cyst <input type="checkbox"/> Cancer <input type="checkbox"/> Precancerous/Aypia <input type="checkbox"/> Other _____		
Gynecological <input type="checkbox"/> Cervical cancer <input type="checkbox"/> Uterine cancer <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> HPV/Condyloma <input type="checkbox"/> Syphilis <input type="checkbox"/> DES exposure <input type="checkbox"/> Fibroids		<input type="checkbox"/> Ovarian cancer <input type="checkbox"/> Polycystic ovaries <input type="checkbox"/> Vulvar cancer <input type="checkbox"/> Herpes <input type="checkbox"/> HIV/AIDs <input type="checkbox"/> PID <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Pelvic prolapse	Surgical treatment: <input type="checkbox"/> No surgery <input type="checkbox"/> Node dissection <input type="checkbox"/> Lumpectomy <input type="checkbox"/> Mastectomy <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation		
		Family History Check All That Apply.			
		WHO? <input type="checkbox"/> Breast Cancer _____ <input type="checkbox"/> Colon Cancer _____ <input type="checkbox"/> Ovarian Cancer _____ <input type="checkbox"/> Heart Attach/dz _____		WHO? <input type="checkbox"/> Birth Defects _____ <input type="checkbox"/> Osteoporosis _____ <input type="checkbox"/> Stroke _____ <input type="checkbox"/> Blood Clots _____	
Social History Marital <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> In a current relationship		Habits <input type="checkbox"/> Current Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Dieting <input type="checkbox"/> Drink Alcoholic Beverages <input type="checkbox"/> 2 or less a day <input type="checkbox"/> more than 2 a day		Exercise <input type="checkbox"/> None <input type="checkbox"/> Regular Exercise <input type="checkbox"/> Aerobic <input type="checkbox"/> Strength Training <input type="checkbox"/> < 3 Times/Week <input type="checkbox"/> > 3 Times/Week	
		Street Drug Use <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Hallucinogens <input type="checkbox"/> Other _____			