Swan Urogynecology, PC
329 21st Ave North
Nashville, TN 37203-1857
(615) 515-9180

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE
	☐ Full-Time ☐ Part-Time					

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-time ☐ Part-time				

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I authorize payment of medical benefits to be made directly to Dr. Swan and/or Dr. Brennan. I agree to pay my portion including co-payments, co-insurance, deductibles and non-covered servicesat the time services are rendered. I understand my visit will be billed to my insurnce if I have provided all appropriate insurance information on this form and copies of my insurance cards. I understand and agree (regardless of my insurance status) that I am ultimately responsible for payment of all professional services rendered by Dr. Swan and/or Dr. Brennan. I also understand a finance charge will be added to each charge on my account that is not paid within 90 days. (Finance charges will not be added to charges awaiting payment from insurance.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

UROGYNELOGICAL HISTORY

Michael Swan, MD

Patient Name:_____ **Date:**_____

Patient DOB:_____ **Race:**_____ **Married:**_____

Main Reason for Visit:_____

Allergies:_____

CURRENT MEDICATIONS

Name of Medication: **Dose:** **How taken:**

_____

_____

(need more room list meds on back of sheet & check box) ☐

GYN HISTORY

Total Pregnancies:_____ **Full Term:**_____ **Premature:**_____

Miscarriages:_____ **Abortions:**_____ **Your age at 1st Birth:**____

MENSTRAL CYCLE HISTORY (circle all that apply)

Age of First Period:_____ **Last Period:**_____ **Duration of Periods:**_____

Flow of Periods: Heavy Medium Light Absence of Periods

Bleeding between Periods Painful Periods Menopausal Symptoms

URINARY (circle all that apply)

Frequency Urgency without Leakage Urgency with Leakage Hesitancy

Unable to Fully Empty Bladder Painful Urination Frequent Urination at Night

Blood in Urine Frequent Infections Kidney Stones Leakage with cough, sneeze

PERSONAL MEDICAL HISTORY (circle all that apply)

Diabetes	Thyroid Disease	Heart Disease	Fibroids
Kidney Disease	High Blood Pressure	Infectious Disease	Pelvic Pain
Abnormal Paps	Ovarian Cysts	Fecal Incontinence	Constipation
Cancer (type)	Other:_____		

PAST SURGERY

What Kind of Surgery: When:

_____

_____

(need more room list surgery on back of sheet & check box) ☐

FAMILY MEDICAL HISTORY (circle all that apply)

(Include who in family & which side of family)

Diabetes	Heart Disease	Thyroid Disease
High Blood Pressure	Kidney Disease	Cancer (Type)
Other:_____		

PERSONAL SOCIAL HISTORY (circle all that apply)

Smoker:	Yes	or	No	Type:	Amount/How Often
Alcohol:	Yes	or	No	Type:	Amount/How Often
Caffeine:	Yes	or	No	Type:	Amount/How Often
Exercise:	Yes	or	No	Type:	Amount/How Often

Dr. Michael Swan Urogynecology

Urogynecology and Surgery

Diplomat American Board of Obstetrics and Gynecology

Patient Financial Policy

Regarding Insurance:

As a courtesy to our patients, we gladly file your insurance claims for you. However, we do require your co-pay at the time of service. The balance is your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 45 days, the balance will be automatically due and we must receive payment from you in full at that time. We will continue to re-file and work with you and your insurance company to get the payment due.

Collection Charges and Legal Fees:

In the event your account is placed with an outside agency for collection, you agree to pay all collection cost, court cost and attorney fees incurred to collect your account. Carrying a balance with this office constitutes a credit transaction and as such you authorize us, or our agent, to report credit activity to the credit bureaus. I also authorize you or your agent to check for address and employment should that be necessary to effect collection.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy and I agree to the above and understand my part.

Signature: _____

Print Name: _____

Date: _____

329 21st Avenue North, Suite 1 Nashville, TN 37203

Ph: 615-515-9180 / Fax: 615-284-7985

Dr. Michael Swan Urogynecology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_____ acknowledge that I have received a copy of Michael Swan MD's Notice of Privacy Practices. This notice describes how Michael Swan MD may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

Signature of Patient or Patient Representative Date

_____

Relationship to Patient

Patient was unable to sign due to_____

_____ _____

Signature of Employee Date

HOW I PERFER TO BE CONTACTED

I may be contacted in the following manner (Check all that apply):

Home

( ) OK to leave detailed information

( ) Leave message with call back information only

Work

( ) OK to leave detailed information

( ) Leave message with call back information only

Written Communication

( ) OK to mail to my home address

( ) OK to mail to my work address

( ) OK to fax to this number_____

My Medical information my be released to the following people:

_____

I verify the accuracy of the above information, and authorize the release of any medical information to any physicians, and insurance carriers. I hereby authorize payment directly to the physician benefits due to me from my insurance otherwise payable to me. I accept full responsibility of my charges. A copy of this authorization may be used in lieu of the original.

_____ _____

Signature of Patient or Patient Representative Date

_____

Relationship to Patient

BLADDER SATISFACTION SURVEY

Name_____ Phone #_____

Which symptoms best describe you?

☐Frequent Urination – Day, Night, or Both ☐Leaking with Sneezing, Coughing, Exercising

☐Sudden or Strong Urge to urinate ☐Leaking with Urge or No Warning - Unable to make it to the bathroom in time

☐Unable to Empty the Bladder ☐Bladder or Pelvic Pain

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? ☐Yes ☐No

If yes, check the medications you have tried:

☐Detrol LA ☐Ditropan XL ☐Flomax ☐Cardura

☐Oxytrol Patch ☐Enablex ☐Vesicare ☐DDAVP

☐Sanctura ☐Elavil ☐Elmiron ☐Other_____

Did these medications help your symptoms? Circle #

No Relief - 0 1 2 3 4 5 6 7 8 9 10 - *Completely Cured*

If you have stopped taking your medications explain why:

☐Did not Help ☐Side Effects ☐Too Expensive

Describe Side Effects _____

What is your level of frustration with your bladder symptoms? Circle #

Not Frustrated- 0 1 2 3 4 5 6 7 8 9 10- *Very Frustrated*

Do you have any bowel issues? Check which ones:

Fecal Incontinence_____ Constipation_____ Other_____

What is your level of frustration with your bowel symptoms? Circle #

Not Frustrated - 0 1 2 3 4 5 6 7 8 9 10 - *Very Frustrated*

Being dry (both bladder & bowel) is <u>possible</u>, would you like to hear about alternative treatment options?

☐Yes ☐No