DATE _____

PATIENT REGISTRATION

1. PATIENT INFORMATION

FIRST NAME _____ MIDDLE ____

LAST NAME _____

SOCIAL SECURITY # _____

SEX ☐M OR ☐F DATE OF BIRTH _____

MARITAL STATUS: ☐MARRIED ☐SINGLE ☐DIVORCED ☐WIDOWED ☐OTHER

CHECK ONE: ☐EMPLOYED ☐RETIRED ☐FULL TIME STUDENT

EMPLOYER _____

RACE/ETHNICITY _____

MAILING ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

DOC ☐ may or ☐ may not leave medical information and test results left on my voicemail at _____

HOME PHONE (____) _____

CELL PHONE (____) _____

WORK PHONE (____) _____

EMAIL _____

2. INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST)

INSURANCE COMPANY _____

SUBSCRIBER NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ SUBSCRIBER RELATIONSHIP _____

POLICY # _____ GROUP # _____ PHONE (_____) _____

3. SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____

SUBSCRIBER NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ SUBSCRIBER RELATIONSHIP _____

POLICY # _____ GROUP # _____ PHONE (_____) _____

4. EMERGENCY CONTACT

FIRST NAME _____ MIDDLE ____

LAST NAME _____PHONE_____

FIRST NAME _____ MIDDLE ____

LAST NAME _____PHONE_____

5. HOW DID YOU HEAR ABOUT US?

☐ REFERRING PHYSICIAN_____

☐ FRIEND/FAMILY_____

☐ INTERNET/GOOGLE

☐ FACEBOOK

☐ RADIO

☐ TV

☐ NEWSPAPER

☐ INSURANCE (PREFERRED PROVIDER)

6. OTHER INFORMATION

LIST NAMES OF UP TO TWO PEOPLE WITH WHOM THE DOCTOR MAY DISCUSS YOUR HEALTH INFORMATION

1. _____ 2. _____

I hereby authorize release of any information required to process insurance claims related to my medical and/or surgical care. I authorize direct payment to the provider/s for my medical and/or surgical care. I understand that I am responsible to pay any non-covered services. I understand that if I am uninsured, I am responsible to pay for any services provided. I have read and agree to the Patient Financial Policy.

_____ _____

SIGNATURE DATE

Annual Update

Name: _____DOB: _____Date:_____

Reason for today's visit: _____

Please list any other Physicians you are currently seeing: _____

Date of last Pap/Annual: _____ Date of abnormal pap's in past: _____

Treatment for abnormal pap's: _____

Last mammogram: _____ done where:_____ (circle one) Normal Abnormal

Last bone scan:_____ Last colonoscopy:_____

How old were you when your first period started: _____
How many times have you been pregnant: _____ How many live births: _____
Have you had your Gardasil series: Yes No

ALL MEDICATIONS, HERBS SUPPLEMENTS, (including prescribing provider and dosage):
_____
_____

List all Drug/Food/Other Allergies: _____
Please list all past surgery(s):_____

What is your current method of birth control: _____
When was the first day of last period: _____ Are you currently sexually active: _____
Days of total flow: _____ Describe your flow: (circle one) light / moderate / heavy
Are they regular: Yes No Painful: Yes No
Cycle length (example: first day of period your period to first day of the next period.): _____
Do you bleed between periods: _____

Social History:

____Married ____Single
Do you smoke tobacco: Yes No Number of packs per day ____ for ____ years Quit (when) _____
Do you chew tobacco: Yes No Do you smoke marijuana: Yes No
Do you drink alcohol: Yes No Number of drinks per day _____ and/or drinks per week _____
Are you at risk for Hepatitis or AIDS: Yes No
Do you have a history of, or are you currently using IV drugs: Yes No

Review of Systems: Have you experienced any of the following in the past 6 months?

- ☐ Depression/Anxiety
- ☐ Problems with sleep
- ☐ Heart palpitations
- ☐ Cough
- ☐ Difficulty swallowing
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Breast problems
- ☐ Skin changes (moles, sores)
- ☐ Stiffness/joint pain
- ☐ Vomiting
- ☐ Nausea
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Rectal bleeding
- ☐ Vaginal discharge
- ☐ Vaginal odor
- ☐ Vaginal itching
- ☐ Bleeding with intercourse
- ☐ Painful intercourse
- ☐ Painful urination
- ☐ Urinary frequency
- ☐ Urinate during the night, how often _____
- ☐ Blood in urine
- ☐ Hot flashes
- ☐ Weight change
- ☐ Tremors
- ☐ Fatigue
- ☐ Excessive thirst
- ☐ Dizziness

What medical problems you are having today: _____

What is your physical activity level per week: _____
Do you feel safe at home and work: Yes No
Do you want to be screened today for sexually transmitted infections: Yes No

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What to Expect at your Annual Well-Woman Exam

The annual well-woman exam is an essential part of your ongoing health maintenance. Despite changes in recommendations for certain tests, such as Pap tests, a regular annual exam is strongly recommended. Many health insurance companies will cover most, if not all, of the charges associates with this type of visit, with little or no co-pay on your part. Please check with your insurance company to determine how your visit will be covered.

A normal annual well-woman exam includes the following:

- Overall assessment of:
  - Health status and physical activity
  - Menstrual/contraceptive status
  - Sexual health and sexual activity
  - Tobacco, alcohol and drug use
  - The need for periodic health screening tests (examples: Pap test, cholesterol, mammograms)
  - Discussion of specialty-appropriate medications and refills
- A gynecologic-oriented physical exam, including:
  - Height
  - Weight
  - Body Mass Index (BMI)
  - Abdominal exam
  - Breast exam
  - Pelvic exam
- Other tests/exams that may be performed:
  - Vaccinations for flu, human papillomavirus (HPV)
  - Chlamydia and gonorrhea
  - HIV testing for sexually active adolescents and adults

Important Note:
The intent of the annual well-woman visit is for **routine** health maintenance. The assumption is that you do not have specific medical problems or conditions. If you wish to discuss additional issues, please let the Front Desk know so they can schedule additional time for this.

If you are evaluated for a **problem-oriented** issue by your provider (e.g., infections, sexual dysfunction, abdominal bleeding, back pain, sleeping problems), you or your insurance may be billed separately and in addition to your well-woman visit since problem-oriented visits usually necessitate a separate office visit. Depending on your insurance, you may be responsible for additional fees for the problem-oriented portion of your visit. Please review your insurance coverage for information on what is covered as part of your visit.

If you have any questions, please call us – Thank you for choosing Denali OB-GYN Clinic!

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