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

New Patient History

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: _____ (choose one) Normal ○ Abnormal ○

Last bone scan: _____ Last colonoscopy: _____

Last blood tests: _____ Ordered by: _____

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

_____

_____

_____

List all Drug/Food/Other Allergies: _____

_____

Medical Problems (hypertension, diabetes, etc.) _____

Please list all past surgery(s) and hospitalizations: _____

Have you had your Gardasil series: Yes ○ No ○

What is your current method of birth control: _____

How old were you when your first period started: _____

When was the first day of last period: _____

Are you currently sexually active: Yes ○ No ○

Do you bleed between periods: Yes ○ No ○

Are they regular: Yes ○ No ○ Painful: Yes ○ No ○

Days of total flow: _____ Describe your flow: (circle one) light ○ moderate ○ heavy ○

Cycle length (example: first day of period your period to first day of the next period): _____

Pregnancy Information:

Total pregnancies: _____

Live births: _____ Stillborn: _____

C-section: _____ Ectopic: _____

Miscarriage: _____ Living children: _____

Family History: Has anyone in your immediate family (Mom, Dad, Sister, Brother) been diagnosed with any of the following

____ Thyroid problems	____ High Blood Pressure		____ Bleeding problems
____ High Cholesterol	____ Alcoholism	____ Heart Disease	____ Osteoporosis
____ Diabetes	____ Depression	____ Stroke	Cancer (type) _____

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 ○

What is your physical activity level per week: _____

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

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have been offered a copy of Denali OB-GYN Clinic's Notice of Privacy Practices.

_____	_____
Patient Signature	Date
_____	_____
Patient Legal Representative (If applicable)	Date
_____	_____
Print Name of Legal Representative	Date

FOR CLINIC USE ONLY:

Denali OB-GYN group made the following good efforts to obtain the above referenced individuals written acknowledgement of receipt of the Notice of Privacy Practice:

(*Identify the efforts that were made to obtain the individual's written acknowledgement, including why (if known) the written acknowledgement was not obtained.*)

Denali OB-GYN Clinic
3976 University Lake Drive, Ste 300 • Anchorage, Alaska
99508 Phone: 907.222.9930 • Fax: 907.222.9931