

DATE _____

PATIENT REGISTRATION

1. PATIENT INFORMATION

FIRST NAME _____ MIDDLE _____ MAILING ADDRESS _____
 LAST NAME _____
 SOCIAL SECURITY # _____ CITY _____ STATE _____ ZIP _____
 SEX M OR F DATE OF BIRTH _____ DOC may or may not leave medical information and
 test results left on my voicemail at _____
 MARITAL STATUS: MARRIED SINGLE DIVORCED HOME PHONE (____) _____
 WIDOWED OTHER
 CHECK ONE: EMPLOYED RETIRED FULL TIME STUDENT CELL PHONE (____) _____
 EMPLOYER _____ WORK PHONE (____) _____
 RACE/ETHNICITY _____ 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 _____ FIRST NAME _____ MIDDLE _____
 LAST NAME _____ PHONE _____ LAST NAME _____ PHONE _____

5. HOW DID YOU HEAR ABOUT US?

- REFERRING PHYSICIAN _____ RADIO
 FRIEND/FAMILY _____ TV
 INTERNET/GOOGLE NEWSPAPER
 FACEBOOK 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?

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

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



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 associated 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!