

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



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 | ___ 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?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Problems with sleep | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Vaginal odor | <input type="checkbox"/> Vaginal itching | <input type="checkbox"/> Appetite changes |
| <input type="checkbox"/> Changes in hair/nails | <input type="checkbox"/> Weight change | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Tremors | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Stiffness/joint pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Cold intolerance |
| <input type="checkbox"/> Bleeding with intercourse | <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Insomnia | |
| <input type="checkbox"/> Skin changes (moles, sores) | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Breast lump | <input type="checkbox"/> Nipple discharge |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> 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.)





Patient Financial Policy Summary

The physicians and staff at Denali OB-GYN clinic value the trust and responsibility you place in us to care for you. In the interest of good practice, we believe that it is desirable to establish a financial policy for our patients. Our goal is to avoid any miscommunication or concerns regarding financial matters, so that we can focus our energies on serving your health care needs. Please ask our staff if you have any questions or concerns about this.

Patients are responsible for payment for all medical treatments and services provided. Insurance deductibles and co-pays will be collected at each office visit. Additional co-pays and/or coinsurance may be collected if additional services are rendered. Insurance co-pays for elective surgery shall be collected prior to the day of surgery.

Our office participates with Medicare, Medicaid, and other healthcare insurance plans. As a service to our patients, we will file insurance claims for all covered services on your behalf. Please check with our office staff to verify that we participate with your insurance plan. As a participating provider network, we will accept the insurance company's allowable payment for covered services.

- Patients are responsible for deductibles, co-payments, non-covered services, and out of network services. Payment for these services shall be due at the time of the visit. We do our best to estimate your insurance payment, but all plans are different and other factors may apply. A balance above the estimated amount will be the patient's responsibility to pay.
- Please provide a current copy of your insurance card at each visit. It is the patient's responsibility to know and understand their insurance benefits. Patients must advise our office staff of the need for precertification by your insurance for any service
- Our office accepts cash, checks, Visa, and MasterCard. All payments are expected at the time of service, unless prior arrangements have been made with the billing department. Past due accounts may be referred to an outside collection service, unless prior arrangements have been made.
- For non-insured patients, a representative will meet with you on an individual basis to discuss payment arrangements.

Our office schedules your appointment time specifically for you. Please notify the office at least 24 hours prior to your scheduled appointment if you will be unable to keep it. This time allows us to offer that appointment to someone else. If a patient fails to show up for their appointment without proper notification, our office reserves the right to charge a \$25.00 fee to your account. This fee will not be billed to your insurance company.

I have read and fully understand the Denali OB-GYN clinic patient financial policy summary.

Signature of Patient and/or Guardian: _____

Printed Name of Patient and/or Guardian: _____ Date: _____

Patient Date of Birth: _____