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

Patient History

Denali OB-GYN Clinic

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: _____

Last blood tests: _____ Ordered by: _____

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

_____

_____

Preferred Pharmacy: _____

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: _____ Abortions: ____

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	___Low back pain
___Skin changes (moles, sores)	___Breast tenderness	___Breast lump	___Nipple discharge
___Painful urination	___ Blood in urine	___Urinate during the night, how often _____	

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

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

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: _____

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