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

Pregnancy Information:
Total pregnancies: _____
Live births: _____ Stillborn: _____
C-section: _____ Ectopic: ______
Miscarriage: ____ Living children: ______

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): ___________

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.*)

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: _____________________