



# WELCOME

Dear Patient:

Welcome to Alliance Obstetrics & Gynecology, PLC. **Please arrive twenty minutes prior to your actual appointment time to complete your registration.** Our database questionnaire and registration forms may be completed by printing the forms below or you may complete them by going to our website and clicking online services. If you choose to print the forms, please mail them to our office prior to your visit. If these forms are not complete when you arrive, it may be necessary to reschedule your appointment.

If you are being referred to us by a physician or have an ongoing problem, please have the pertinent portion of your medical record forwarded to our office. If you are a self referral and have no ongoing problems, we do not need a copy of your medical records forwarded.

Prior to your office visit, please check with your insurance company to see if an authorization is required for your appointment. Also, please bring your insurance card so that we may copy it for our records.

This appointment time has been set aside for you and the provider to discuss your care. If you are unable to keep this appointment please notify our office 24 hours prior to your appointment. If you do not cancel your appointment in the designated time we may be unable to reschedule your appointment.

Thank you for choosing Alliance Obstetrics and Gynecology, PLC for your health care.

Sincerely,

Sara Cramton, M.D.  
Stephanie Fleming, M.D.  
Maude Guerin, M.D.  
Melissa Halvorson, M.D.  
Cristina Horton, M.D.  
Sharon Kelley, M.D.  
Todd Moyerbrailean, D.O.  
LaKeeya Tucker, D.O.

M. Elizabeth Cross, C.N.M.  
Nicole Jamieson, R.N., N.P.  
Laura Kelly, R.N., N.P.  
Susan Mackenzie, C.N.M., N.P.  
Elizabeth Price, R.N., N.P.  
Diane Strachan, R.N., N.P.  
Stacey Tanay, R.N., N.P.  
Jennifer Thomas, R.N., N.P.

# Alliance Obstetrics and Gynecology

## PATIENT INFORMATION

NAME (FIRST)		(M)	(LAST)
HOW WOULD YOU LIKE TO BE ADDRESSED?			
BIRTHDATE		SOCIAL SECURITY	
HOME ADDRESS			APT #
CITY		STATE	ZIP
TELEPHONE # HOME ( )	WORK ( )	EXT:	CELLULAR ( )
YOUR EMPLOYER			
FAMILY DOCTOR		DOCTOR THAT REFERRED YOU HERE	
<b>THIS SECTION MUST BE COMPLETED FOR US TO BILL YOUR INSURANCE</b>			
<u>PRIMARY INSURANCE COMPANY</u>			
POLICY HOLDER		SSN#	
YOUR RELATIONSHIP TO POLICY HOLDER			
CONTRACT#		GROUP #	
SUBSCRIBER'S EMPLOYER			
POLICY HOLDER BIRTHDATE			
<u>SECONDARY INSURANCE COMPANY</u>			
POLICY HOLDER		SSN#	
YOUR RELATIONSHIP TO POLICY HOLDER			
CONTRACT#		GROUP #	
SUBSCRIBER'S EMPLOYER			
POLICY HOLDER BIRTHDATE			
EMERGENCY CONTACT PERSON		RELATIONSHIP	
TELEPHONE: HOME ( )	WORK ( )		
IF PATIENT IS MINOR: RESPONSIBLE PARTY			

### RELEASE AND ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. I AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO ALLIANCE OBSTETRICS AND GYNECOLOGY, TIN# 38-3381725. I HAVE BEEN PROVIDED WITH A COPY OF THE ALLIANCE FINANCIAL POLICY AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

# Alliance OB/GYN Medical History Update

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## 1. Allergies (please list):

Medications:

Foods:

Latex?

Iodine ?

## 2. Immunizations (Give dates):

- yes no tetanus
- yes no hepatitis
- yes no hemophilus Influenza Type B
- yes no MMR (measles, mumps, rubella)
- yes no The "flu" shot
- yes no Gardasil Circle # of doses received 1 2 3 \_\_\_\_\_

## 3. Family Medical History (List family member):

- yes no breast cancer \_\_\_\_\_ paternal/maternal
- yes no ovarian cancer \_\_\_\_\_ paternal/maternal
- yes no uterine cancer \_\_\_\_\_ paternal/maternal
- yes no cervical cancer \_\_\_\_\_ paternal/maternal
- yes no bowel (colon) cancer \_\_\_\_\_ paternal/maternal
- yes no deep vein thrombosis (DVT) \_\_\_\_\_ paternal/maternal
- yes no essential hypertension \_\_\_\_\_ paternal/maternal  
(high blood pressure)
- yes no heart disease \_\_\_\_\_ paternal/maternal
- yes no insulin dependent diabetes \_\_\_\_\_ paternal/maternal
- yes no noninsulin dependent diabetes \_\_\_\_\_ paternal/maternal
- yes no osteoporosis \_\_\_\_\_ paternal/maternal
- yes no pulmonary embolism \_\_\_\_\_ paternal/maternal
- yes no stroke \_\_\_\_\_ paternal/maternal

## 4. Past Medical History (Have you ever had):

Head, Eyes, Ears, Nose & Throat:

- yes no deafness
- yes no blindness
- yes no glaucoma
- yes no cataract

Cardiovascular System:

- yes no heart disease
- yes no high cholesterol (hypercholesterolemia)
- yes no high blood pressure (hypertension)
- yes no mitral valve prolapse
- yes no peripheral vascular disease
- yes no pulmonary embolism
- yes no Raynaud's Syndrome
- yes no rheumatic heart disease

Breast:

- yes no breast abscess
- yes no breast lump
- yes no breast cancer
- yes no fibrocystic disease of the breast
- yes no carcinoma insitu of the breast
- yes no breast cyst
- yes no benign neoplasm of the breast

Respiratory System:

- yes no asthma

Gastrointestinal System:

- yes no appendicitis
- yes no gall stones (cholelithiasis)
- yes no cirrhosis of the liver
- yes no Crohn's disease
- yes no diverticulitis
- yes no stomach ulcers
- yes no irritable bowel syndrome
- yes no ulcerative colitis

Genitourinary System:

- yes no infertility
- yes no kidney disease
- yes no pelvic inflammatory disease
- yes no Premenstrual syndrome (PMDD)
- yes no endometriosis
- yes no chronic bladder infections (cystitis)
- yes no interstitial cystitis
- yes no kidney stones (nephrolithiasis)
- yes no chronic vaginitis
- yes no lichen sclerosis

Dermatological System:

- yes no acne
- yes no skin cancer, type:
- yes no lupus (SLE)

## Alliance OB/GYN Medical History Update

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### Endocrine System:

- yes no goiter
- yes no Graves' disease
- yes no Hashimoto's thyroiditis
- yes no benign thyroid tumor
- yes no thyroid cancer
- yes no gestational diabetes
- yes no insulin dependent diabetes
- yes no noninsulin dependent diabetes
- yes no unwanted hair growth (hirsutism)
- yes no polycystic ovarian disease

### Hematological System:

- yes no alpha thalassemia
- yes no beta thalassemia
- yes no deep vein thrombosis (DVT)
- yes no hemophilia A/ hemophilia B
- yes no pulmonary embolism
- yes no blood transfusion
- yes no von Willebrand's disease
- yes no Thrombophilia (blood clotting difficulties).

### Musculoskeletal System:

- yes no chronic arthritis
- yes no osteopenia
- yes no osteoporosis

### Neurological System:

- yes no migraines
- yes no epilepsy
- yes no multiple sclerosis
- yes no myasthenia gravis
- yes no Parkinson's disease

### Psychiatric System:

- yes no alcohol abuse
- yes no anorexia nervosa
- yes no anxiety disorders
- yes no bulimia nervosa
- yes no depression

**5. Surgical History (Have you ever had):**

Breast Surgery:

yes no lumpectomy  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no breast implants (augmentation)  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no breast reduction  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no total mastectomy  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

Cardiovascular Surgery:

yes no coronary bypass  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no valve replacement  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

Gastrointestinal Surgery:

yes no appendectomy  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no surgery for weight loss (Bariatric)  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no gall bladder (cholecystectomy)  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no colostomy  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no hernia (incisional, umbilical)  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no large bowel resection  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no small bowel resection  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

Gynecologic Surgery:

yes no anterior repair (colporrhaphy)  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no posterior repair (colporrhaphy)  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no D&C  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no endometrial ablation  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no hysterectomy (abd, vag lapscopic)  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no laparoscopy  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no ovarian cystectomy  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

yes no tubal ligation  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

Urologic Surgery:

yes no bladder suspension (burch, sling, TVT)  
Date\_\_\_\_\_ Dr. \_\_\_\_\_

Neurologic Surgery:

yes no laminectomy  
Date\_\_\_\_\_ Dr. \_\_\_\_\_

Lymphatic/Hematologic Surgery:

yes no bone marrow transplant  
Date\_\_\_\_\_ Dr. \_\_\_\_\_

yes no lymph node biopsy  
Date\_\_\_\_\_ Dr. \_\_\_\_\_

yes no splenectomy  
Date\_\_\_\_\_ Dr. \_\_\_\_\_

Musculoskeletal Surgery:

yes no total hip replacement L R B  
Date\_\_\_\_\_ Dr. \_\_\_\_\_

yes no total knee replacement L R B  
Date\_\_\_\_\_ Dr. \_\_\_\_\_

Vascular Surgery:

yes no varicose vein stripping/ligation  
Date\_\_\_\_\_ Dr. \_\_\_\_\_

Skin Surgery:

yes no excision of skin cancer Type \_\_\_\_\_  
Date\_\_\_\_\_ Dr. \_\_\_\_\_

yes no genital wart excision  
Date\_\_\_\_\_ Dr. \_\_\_\_\_

Endocrine System Surgeries:

yes no parathyroidectomy  
Date\_\_\_\_\_ Dr. \_\_\_\_\_

yes no thyroidectomy (total/subtotal)  
Date\_\_\_\_\_ Dr. \_\_\_\_\_

Additional Surgeries (Include Date & Dr.):

## 6. Social History:

Exercise History (circle all that apply):

Inactive light moderate heavy vigorous Daily 2x per week 3x per week  
Aerobics biking jogging running stretching/balance swimming treadmill walking weight  
lifting yoga

Living situation (circle all that apply):

Lives alone with spouse divorced married single significant other

Occupation: \_\_\_\_\_

Alcohol/Tobacco/Illicit drug use:

yes no tobacco use  
yes no previous smoker  
yes no illicit drug use  
yes no alcohol use  
yes no verbal abuse  
yes no sexual abuse  
yes no physical abuse

Birth control method (circle all that apply):

None abstinence condoms spermicide Norplant Depo-Provera diaphragm  
IUD oral contraceptives vasectomy rhythm method tubal ligation

Safety History:

yes no safety belt use  
yes no helmet use







To All Patients,

The intent of this document is to inform you of Alliance Obstetrics & Gynecology's Financial Policy. It is our objective and philosophy that all our patients receive the best possible care and service. Therefore, your complete understanding of our financial policy as it relates to your financial obligation is essential. Please read this document thoroughly. When you present to the office you will be asked to sign a form stating that you have read, understand and will comply with the information contained within this document.

- ❖ If you are a member of a health plan that Alliance OBGYN participates with, we will submit your claim to your insurance company. Your co-payment is expected at the time services are rendered. Patients will be billed in full for any services that their health plan deems as "not a benefit" or a "non-covered service".
- ❖ If Alliance OBGYN does not participate with your insurance carrier, payment in full will be required by you at the time services are rendered. Our Billing Department will send a bill to your insurance company as a courtesy to you. (*Maternity care and hospital services are arranged separately.*)
- ❖ Medicare patients are responsible for their deductible, co-insurance and any services Medicare might deem as "Medically Unnecessary". Medicare patients may also be asked to sign an Advanced Beneficiary Notice (ABN) form as required by Medicare for certain services.
- ❖ Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. For minors, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred.
- ❖ There may be additional charges applied to your account if Alliance OBGYN is asked to participate in a Deposition, Phone Consultation, copying of Medical Records or completion of forms pertaining to your medical history.
- ❖ There is a \$25 fee for Medical records requests. Payment for these records will be collected prior to records being released. If applicable, a complimentary copy of your records will be sent to the physician of your choice.
- ❖ Alliance OBGYN accepts Cash, Personal Check, Money Orders, Travelers Checks, Discover, Mastercard, Visa, and ATM debit cards as payment for services rendered.
- ❖ A \$35 fee will be assessed for any check returned for insufficient funds. At that time only cash, charge or money order will be accepted for payment.
- ❖ Alliance OBGYN reserves the right to turn any account over to collections if it is deemed that the account has been in default of payment or compliance with this policy. In the event you breach this agreement, you agree to pay all collections fees, including attorney's fees, incurred by us in enforcing the terms hereof, whether or not formal legal proceedings are commenced.
- ❖ If you must cancel an appointment Alliance requires a minimum of 24 hours notice. Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment will result in a charge of \$75.00.