Jamison C. Alexander, D.O., F.A.C.O.G.

Obstetrics and Gynecology

3401 N. Calais Street, Suite B, Sherman, Texas 75090. Phone 903.892.8222. Fax 903.892.8444

PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Legal Name (*First, M.I., Last)*_____ Former Name:_____

Date of Birth _____ Age _____ Male / Female Marital Status: S M W D

Ethnicity:_____ Race:_____

Address _____

Home Phone #: _____ Mobile Phone #:_____ Email:_____

Social Security # _____ Driver's License #_____

Employer _____ Phone _____

Employer Address _____

Referring Physician _____ How did you hear about our clinic?_____

If Student, School Name _____ Full-Time / Part-Time

Emergency Contact _____Relationship:_____ Phone Number _____

Responsible Party
(Person responsible for financial arrangements)

Name _____ Relationship to Patient _____

Address_____

Phone Number _____ Social Security # _____ Driver's License#_____

Employer _____ Phone Number _____

Employer Address_____

Insurance Information

NOTE TO MEDICAID PATIENTS: Insurance claims must be filed to ANY active commercial health insurance policy **you** are listed on (self, spouse, parent, stepparent policy, etc) BEFORE the claim is forwarded to a Medicaid program. If a commercial policy exists, it must be listed as your primary insurance policy and your Medicaid will be your secondary policy. By law, Medicaid is ALWAYS the payer of LAST RESORT.

PRIMARY Insurance Company _____ Phone Number _____

Claim Address _____

Group # _____ Certificate or ID # _____

Insured's (Subscriber) Name _____ Relationship to Patient: Self / Spouse / Dependent

Insured's (Subscriber) Address: _____ Phone Number: _____

Insured's Social Security # _____ Date of Birth _____ Male / Female

Insured's (Subscriber) Employer _____ Phone Number _____

Employer Address _____

SECONDARY Insurance Company _____ Phone Number _____

Claim Address _____

Group # _____ Certificate or ID # _____

Insured's (Subscriber) Name _____ Relationship to Patient: Self / Spouse / Dependent

Insured's (Subscriber) Address: _____ Phone Number: _____

Insured's Social Security # _____ Date of Birth _____ Male / Female

Insured's (Subscriber) Employer _____ Phone Number _____

Employer Address _____

I hereby assign, transfer, and set over to Jamison Alexander, DO, PA all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES, FISCAL AND OFFICE POLICIES ACKNOWLEDGEMENT

I,_____, acknowledge that Jamison Alexander, DO, PA provided me with a copy of Financial and Office Policies and Notice of Privacy Policy. I also acknowledge that I have been afforded the opportunity to review these policies and ask questions. I understand that my financial and medical records are confidential and cannot be disclosed without my prior authorization, except as otherwise provided by law.

I give my permission to Jamison Alexander, DO and his staff to contact me at the following phone numbers. If necessary messages may be left at the contact(s) indicated below:

Home phone #_____ ☐ Messages ☐ No Messages

Mobile phone #_____ ☐ Messages ☐ No Messages

Work phone #_____ ☐ Messages ☐ No Messages

In the event you are unable to make medical decisions for yourself, who may we notify to make those medical decisions for you?

Name:_____ Relationship:_____

Contact phone #_____

Jamison Alexander, DO and his staff have my permission to release medical records and/or financial information to the following individuals:

I authorize the release of the following information to the individual below: ☐ Medical ☐ Financial

Name:_____ Relationship:_____

Home phone:_____ Mobile phone#:_____

I authorize the release of the following information to the individual below: ☐ Medical ☐ Financial

Name:_____ Relationship:_____

Home phone:_____ Mobile phone#:_____

I understand that I have the right to revoke this authorization at any time as long as my request is in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have already acted in reliance upon the authorization.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient

Jamison Alexander, DO

Obstetrics and Gynecology

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Email Consent

I,_____, give Dr Jamison Alexander DO and his staff permission to communicate with me via email as needed.

I can be contacted at the following email address:

_____

Patient Signature:_____ Date:_____

I do not give Dr Alexander and his staff permission to contact via email. I request to be contacted by phone or mail as needed.

Patient Signature:_____ Date:_____

Jamison Alexander, D.O.
Patient Intake History

Obstetric History: Please complete the information below regarding your prior pregnancies. If you have never been pregnant, please write N/A in the first box and proceed to the next section of this form. If you had a miscarriage or abortion, please enter the date, how far into the pregnancy you were, and if you had to have a D&C. The first column is completed as an example for you to follow.

	Date	How Many Weeks at Delivery?	Length of Labor	Birth Wt	Sex (M/F)	Delivery: Vaginal or C-Section	Miscarriage? If yes, did you have a D&C?	Anesthesia? (None, epidural, spinal, iv meds)	What Hospital? City/State	Preterm Labor?	Comments or Complications
Ex	12/2010	39 wks	6 hrs	8lb	M	Vaginal	N/A	Epidural	WNJ Sherman, TX	No	Induced for pre-eclampsia
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

Total number of living children_____

Menstrual History: Please answer the following questions as completely as possible.

1) When was the **first day** of your last normal period?

2) Are your periods regular (Do they occur every month)?

3) How often do your periods occur?

4) How old were you when you first started having periods?

5) Were you on any type of birth control when you became pregnant for this pregnancy?
If so, what were you using?

6) When was your first positive pregnancy test for this pregnancy?

Gynecologic History:

When was your last pap?
Have you ever had the HPV vaccine? Yes or No When:
Have you ever had an abnormal pap? Yes or No If so, when?
Circle any sexually transmitted disease that you have ever been diagnosed with:
None Gonorrhea Chlamydia Syphilis HPV Trichomonas Herpes Genital Warts HIV Other:

Surgical History: Patient Only

Date	Procedure		Details (Laparoscopic, Open, etc)	What hospital and Doctor?
	Hysterectomy	Yes or No		
	Oophorectomy (Ovary Removal)	Yes or No		
	Ovarian Cystectomy			
	C-Section	Yes or No		
	Tubal Ligation	Yes or No		
	Uterine Ablation	Yes or No		
	Tubal Reanastomosis	Yes or No		
	LEEP	Yes or No		
	Cold Knife Cone of Cervix	Yes or No		
	Bartholin's Cyst	Yes or No		
	Bladder Sling	Yes or No		
	Bladder Suspension	Yes or No		
	Appendix	Yes or No		
	Gallbladder	Yes or No		
	Hernia	Yes or No		
	Weight Loss Surgery	Yes or No		

List Other Surgeries Below

Date	Procedure	Details (Laparoscopic, Open, etc)	What hospital and Doctor?

Past Medical History: Please circle yes or no if **you** have any of the following conditions now or in the past. Provide details if needed.

Heart Disease:	Yes	No	Rh Sensitization:	Yes	No
High Blood Pressure:	Yes	No	Pulmonary (TB/Asthma):	Yes	No
Autoimmune Disorder:	Yes	No	Seasonal Allergies:	Yes	No
Kidney Disease/Recurrent UTI:	Yes	No	Drug/Latex Allergies/Reactions:	Yes	No
Neurologic/Epilepsy:	Yes	No	Breast Disease:	Yes	No
Psychiatric Disorder:	Yes	No	Gynecologic Surgery:	Yes	No
Hepatitis/Liver Disease:	Yes	No	Operations/Hospitalization:	Yes	No
Varicosities/Phlebitis:	Yes	No	Anesthetic Complications:	Yes	No
Thyroid Dysfunction:	Yes	No	History of Abnormal Pap:	Yes	No
Trauma/Violence:	Yes	No	Uterine Anomaly/DES Exposure:	Yes	No
History of Transfusion:	Yes	No	Infertility:	Yes	No
Tobacco Dependency:	Yes	No	Relevant Family History:	Yes	No
Before Pregnancy:	Yes	No	Diabetes:	Yes	No
During Pregnancy:	Yes	No			
Alcohol:	Yes	No			
Before Pregnancy:	Yes	No			
During Pregnancy:	Yes	No			
Illicit/Recreational Drugs:	Yes	No			
Before Pregnancy:	Yes	No			
During Pregnancy:	Yes	No			

Details:

Genetic History: Please circle yes or no if you, the baby's father, or anyone in either family have any of the conditions below and provide details.

Maternal age (Patient only) 35 or more at the time of delivery: Yes No
Thalassemia (Italian, Greek, Mediterranean, or Asian Background): Yes No
Neural Tube Defect: Yes No
Congenital Heart Defect: Yes No
Down Syndrome: Yes No
Tay-Sachs: Yes No
Canavan Disease: Yes No
Sickle Cell Trait or Disease: Yes No
Hemophilia or Other Blood Disorders: Yes No
Muscular Dystrophy: Yes No
Cystic Fibrosis: Yes No
Huntington Chorea: Yes No
Mental Retardation/Autism: Yes No
If yes, was the person treated for Fragile X? Yes No
Other inherited genetic or chromosomal disorder? Yes No
Maternal Metabolic Disorder? Yes No
Patient of Baby's Father had a child with birth defects not listed above? Yes No
Recurrent Pregnancy Loss or a Stillbirth? Yes No
Medications/Illicit Drugs/Alcohol since Last Menstrual Period: Yes No
If yes, what?
Any Other:

Infection History: Circle yes or no if you or a close contact have had any of the following:

High risk hepatitis B/Immunized: Yes No
Live with someone with Tuberculosis or exposed to TB: Yes No
Patient or partner with genital herpes: Yes No
Rash or viral illness since last menstrual period: Yes No
History of a sexually transmitted disease: Yes No
Other:

Additional Information:

How tall are you?
How much did you weigh before you became pregnant?

Current Medications

Name	Dose	Who prescribed it?	What do you take it for?
1			
2			
3			
4			
5			
6			
7			

Are you allergic to any medications? If so, list below.

Name of medication	Reaction
1	
2	
3	
4	

Review of Systems

Circle any of the symptoms below that you are having

General: Fatigue Fever Weight Gain Weight Loss

Skin: Abnormal Moles Rash

Ophthalmologic: Irritation Vision Change

Respiratory: Shortness of Breath Chronic Cough

Cardiovascular: Chest Pain Palpitations

Gastrointestinal: Nausea Vomiting Abdominal Pain Blood in Stool

Genitourinary: Blood in Urine Abnormal Bleeding Urinary Incontinence

Breast: Tenderness Breast Lump Nipple Discharge

Endocrine: Menstrual: Irregular Periods Heavy Bleeding Excessive Cramping
Hot Flashes

Musculoskeletal: Weakness Other

Psychiatric: Depression