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

3401 N. Calais Street, Suite B, Sherman, TX 75090. Phone 99903.892.8222 Fax 903-892.8444

## 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

| Name: | Date: |
|---|---|
| Birth Date: | Reason For Visit: |

Current Medications

| Name | Dose | Who prescribed it? | What do you take it for? |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |
| 11 | | | |
| 12 | | | |
| 13 | | | |
| 14 | | | |

Medical History: Patient Only

| | | | |
|---|---|---|---|
| Asthma | Yes or No | Osteoporosis | Yes or No |
| Heart Disease | Yes or No | High Cholesterol | Yes or No |
| Diabetes | Yes or No | Psychiatric Disorder | Yes or No |
| High Blood Pressure | Yes or No | Bleeding Disorder | Yes or No |
| Stroke | Yes or No | Bowel Disorder | Yes or No |
| Thyroid Dysfunction | Yes or No | Seizure Disorder | Yes or No |
| Cancer | Yes or No | Blood Clot (DVT, PE, etc) | Yes or No |
| Kidney Disease | Yes or No | Hepatitis/Liver Disease | Yes or No |
| Tuberculosis | Yes or No | Migraines | Yes or No |
| COPD/Emphysema | Yes or No | GERD/Heartburn | Yes or No |
| Anesthetic Complications? | Yes or No | Infertility/PCOS | Yes or No |
| Other/Details: | | | |

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

| Name of medication | Reaction |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |

Gynecologic History

| | |
|---|---|
| When was the first day of your last menstrual period? | / / |
| How old were you when your periods began? | |
| How many days does your period last? | |
| Number of days between your periods? | |
| Do you have mild, moderate, or heavy bleeding with your periods? | Mild Moderate Heavy |
| Do you have mild, moderate, or severe cramping with your periods? | Mild Moderate Heavy |
| Have you ever been sexually active? | Yes or No |
| Are you currently sexually active? | Yes or No |
| If you are sexually active, how many partners have you had in the last year? | |
| If you are sexually active, are your partners men, women, or both? | Men Women Both |
| Do you have pain with intercourse? | Yes or No |
| Circle any sexually transmitted disease that you have ever been diagnosed with. | None Gonorrhea Chlamydia Syphilis HPV Trichomonas Herpes Genital Warts HIV Other: |
| Circle any prior birth control method(s) you have used. | Pills Patch Injection Ring IUD Implanon Nexplanon Condoms Withdrawal Method Vasectomy Tubal Ligation Essure Adiana None Not Applicable |
| Circle your current birth control method. | Pills Patch Injection Ring IUD Implanon Nexplanon Condoms Withdrawal Method Vasectomy Tubal Ligation Essure Adiana None Not Applicable |
| Circle the birth control method you would like. | Pills Patch Injection Ring IUD Implanon Nexplanon Condoms Withdrawal Method Vasectomy Tubal Ligation Essure Adiana None Not Applicable |
| When was your last pap? | |
| Have you ever had an abnormal pap? If so, when? | Yes or No When: |
| Circle if you have ever had a Colposcopy, LEEP, Cold Knife Cone, or Cervical Cryotherapy? If so, when? | None Colposcopy LEEP Cold Knife Cone Cervical Cryotherapy When: |
| Have you ever had an endometrial biopsy? If so, when? | Yes or No When: |
| When was your last breast exam? | |
| Have you ever had a mammogram? If so, when? | Yes or No When: |
| Have you had your thyroid blood work done? If so, when? | Yes or No When: |
| Have you ever had a bone density test (DEXA Scan) done? If so, when? | Yes or No When: |
| Have you ever had the HPV vaccine? | Yes or No When: |
| Do you have problems controlling your bladder? | Yes or No |
| Do you have problems controlling your bowel? | Yes or No |

**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 | | | | | | | | | | | |

**Total number of pregnancies_____** **Total number of living children_____**

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? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

List Hospitalizations Below

| Date | Reason | Details | What hospital and Doctor? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Family History: Immediate family (Mother, Father, Siblings, Children, Grandparents)

| Illness | Yes or No | Which relatives and age of onset? |
|---|---|---|
| Diabetes | Yes or No | |
| Heart Disease | Yes or No | |
| Stroke/Blood Clot | Yes or No | |
| High Blood Pressure | Yes or No | |
| Breast Cancer | Yes or No | |
| Ovarian Cancer | Yes or No | |
| Colon Cancer | Yes or No | |
| Mental Illness/Depression | Yes or No | |
| Other: | | |

Social History

| | | |
|---|---|---|
| Are you employed? | Yes or No | If yes, what is your current job? |
| Circle your highest education level. | High School Some College College Degree Masters or PhD Vocational | |
| Circle if you are married, single, widowed, divorced, or separated? | Married Single Widowed Divorced Separated | |
| Do you smoke? | Yes or No | If yes, how many packs per day? _____ Packs per day |
| Do you drink alcohol? | Yes or No | If yes, what type and how often? |
| Do you use recreational drugs? | Yes or No | If yes, what do you use and is it injected? |
| Do you exercise? | Yes or No | |

## Review of Systems

Circle any of the symptoms below that you are having

General: Change in appetite Fatigue Fever Night Sweats Other:_____

Ophthalmologic: Vision Change Glasses/Contacts Other:_____

ENT: Ulcers Sinusitis Headache Tinnitus Other:_____

Endocrine: Weight Gain Hot Flashes Temperature Intolerance Weight Loss Other:_____

Respiratory: Shortness of Breath Cough Hemoptysis Wheezing Other:_____

Breast: Breast Lump Breast Pain Nipple Discharge Other:_____

Cardiovascular: Chest Pain Edema Dyspnea on Exertion Orthopnea Palpitations Other:_____

Gastrointestinal: Flatulence Abdominal Pain Blood in Stool Constipation Diarrhea

Nausea Vomiting Other:_____

Hematology: Easy Bruising Prolonged Bleeding Adenopathy Other:_____

Genitourinary: Blood in Urine Frequent Urination Painful Urination Incomplete Emptying

Urinary Incontinence Abnormal Periods Painful Intercourse Vaginal Discharge

Other:_____

Musculoskeletal: Weakness Other:_____

Skin: Ulcer Rash Other:_____

Neurologic: Trouble Walking Syncopy Seizures Tingling/Numbness Other:_____

Psychiatric: Frequent Crying Depressed Mood Other:_____