Welcome!

Welcome to Alliance Obstetrics & Gynecology. We are excited to be providing your Gynecological care.

Prior to your scheduled visit, we recommend that you check with your insurance company around your coverage and to see if an authorization is required for your appointment. A list of insurances that we currently participate with can be found on our website or by clicking the following hyperlink: Participating Insurance List.

We ask that you please come to your New Patient appointment prepared with the following:

- Valid Picture ID (Driver's License/State ID)
- Insurance Card(s)
- Payment for your Copay (if applicable)

For the best experience possible, we recommend that you sign up for your Patient Portal prior to your scheduled visit. Accessing our Patient Portal will allow you to complete pre-check in, message our staff, view your upcoming appointment and so much more. Click HERE to sign up now.

To provide you with the best care, we ask that you please take a moment to answer the following questionnaires. Failure to complete this paperwork 48 hours prior to your scheduled New Patient appointment may result in rescheduling.

Thank you for choosing Alliance Obstetrics and Gynecology for your health care needs, we look forward to meeting you.

Patient Information

Demographics

Legal Last name: *

Legal First Name: *

Middle:

(Former name):

What is your preferred name? *

What are your preferred pronouns?

Is there any additional information you would like to share around your gender identity?

Date of Birth: *

mm-dd-yyyy

Date

Social Security Number:

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Cell Phone *

Area Code - Phone Number

Home Phone

Area Code - Phone Number

Email *

example@example.com

Employer Phone:

Employer:

Preferred Notification Method: *

- Phone
- Postal Mail
- Portal

Family Physician First Name: * **Family Physician Last Name:** *

Emergency Contact

Name of local friend or relative: *

Relationship to patient: *

Cell Phone: *

Home Phone:

Work Phone:

Language: *

Race *

- [ ] Asian
- [ ] Native Hawaiian
- [ ] Other Pacific Islander
- [ ] Black/African American
- [ ] White
- [ ] Unreported/Refuse to Report
- [ ] More than one race

Ethnicity *

- [ ] Hispanic or Latino
- [ ] Not Hispanic or Latino
- [ ] Refused to report

Marital Status *

- ( ) Single
- ( ) Married
- ( ) Divorced
- ( ) Other

Insurance Information

Upload pictures of the front and back of your insurance card.

Browse Files

You can select multiple files

Primary Insurance Name (ex: Blue Cross, BCN, PHP...): *

Subscriber's Name: *

Subscriber Date of Birth: *

mm-dd-yyyy

Date

Patient relationship to subscriber: *

Primary Insurance Enrollee ID or Subscriber # *

Primary Insurance Group ID or Group# *

Secondary Insurance Name (ex: Blue Cross, BCN, PHP...)

Secondary Insurance Subscriber's Name:

Secondary Insurance Subscriber Date of Birth:

mm-dd-yyyy

Date

Secondary Insurance Patient relationship to subscriber:

Secondary Insurance Enrollee ID or Subscriber #

Secondary Insurance Group ID or Group #

Medical History

Please indicate if you need assistance with your visit? (i.e. wheelchair, interpreter service, etc):

Allergies

List the medications to which you are allergic, followed by your reaction to those medications:

Medications

Please fill out the following table with any medications, vitamins or over the counter supplements you are currently taking:

	Medication	Dose (amount)	Frequency (how often taken)

1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Immunizations

Indicate the date of your last immunizations. If you are unaware of the date or have not had, please indicate with N/A. *

	Date
Tetanus Shot	
MMR Shot (measles)	
Flu Shot	
Pneumonia Shot	
Shingles Shot	
Varicella (chicken pox) Shot	
Gardasil (cervical cancer) Shot	
COVID-19	

GYN History

What was the first day of your most recent period? If unknown, please type "unknown": *

Please fill out the following table: *

	Date	Result	N/A
Last Mammogram			
Last Colonoscopy			

Last Bone Density			
Last Pap			
Last HPV			

If you've ever had an abnormal pap, in what year?

Type of Abnormal Pap:

If you've ever had treatment for an abnormal pap smear, what type of treatment have you had?

Have you ever had treatment for any of the following?

	Year
Cryotherapy	
Laser	
Cone Biopsy	
Loop excision (LEEP)	

Are you currently sexually active? *

- ◯ Yes
- ◯ No

Please indicate, are you sexually active with: *

- ◯ Male
- ◯ Female
- ◯ Both
- ◯ Decline

Are you currently using birth control? *

- ◯ Yes
- ◯ No

Birth Control: Type (i.e. IUD, pills, condom, etc)

History of Pregnancy

If you have never been pregnant, please enter 0 in those fields.

Please list your total number of: *

	Number
Pregnancies	

Deliveries Vaginally	
Deliveries C-Section	
Induced Abortion	
Spontaneous Abortion (Miscarriage)	
Ectopic	
Fetal Demise	

Family History

Indicate which, if any, family members have had the following conditions:

	Mother	Father	Brother	Sister	Son	Daughter	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa
Diabetes - Insulin Dependent	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes - Non-Insulin Dependent	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood clots (leg/lungs)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thrombophilia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Social History

Occupation:

Is a blood transfusion acceptable for you in an emergency *

- ○ Yes
- ○ No

What is your exercise level? *

How many times per week do you exercise? *

Do you or have you ever smoked tobacco? *

What is your level of alcohol consumption? *

Are you currently using illicit drugs? *

- Yes
- No

Illicit Drugs: Type

Illicit Drugs: Amount

Are you currently being abused? *

- Yes
- No

Do you have a history of abuse? *

- Yes
- No

History of abuse: Check all that apply. *

- Physical
- Mental
- Verbal
- None

Surgical History

Please list ALL procedures that you have had, along with the year performed:

Patient's Past Medical History

Have you previously been diagnosed with Cancer? If yes, please list the type and year diagnosed:

Have you had genetic testing for Cancer genes (BRCA, Lynch Syndrome...)? If yes, please list the type of testing and the results:

Do you have a history of Cardiovascular problems? If yes, please list the type and year diagnosed:

Do you have a history of Dermatological problems? If yes, please list the type and year diagnosed:

Do you have a history of Ear/Nose/Throat problems? If yes, please list the type and year diagnosed:

Do you have a history of Endocrine problems? If yes, please list the type and year diagnosed:

Do you have a history of Gastrointestional problems? If yes, please list the type and year diagnosed:

Have you had a history of any of the below Gynecological problems?

- [ ] Dysplasia
- [ ] Endometriosis
- [ ] Fibroids
- [ ] Infertility
- [ ] PCOS

Do you have a history of blood disorders? If yes, please list the type and year diagnosed:

Do you have a history of Respiratory problems? If yes, please list the type and year diagnosed:

Do you have a history of Musculoskeletal problems? If yes, please list the type and year diagnosed:

Do you have a history of Neurological problems? If yes, please list the type and year diagnosed:

Do you have a history of Psychiatric/Mood disorder? If yes, please list the type and year diagnosed:

Signature *

Clear

Submit