OGA

Patient Information Sheet

Affix PT label here

☐ New patient ☐ Return patient (Last appt 3+ yrs. ago) ☐ Referral from another Clinic

Patient Information

Last Name:	First Name: M.I		Preferred Name:	
Social Security Number:	Date of Birth:	Cell Phone:	Home Phone:	
Mailing Address:		City:	State:	Zip Code:
Email Address:			Preferred Language:	
Employer:	Employer Address:		Work Phone:	
Primary Care Physician:	Clinic Name:		Clinic Phone:	
Preferred Pharmacy	Pharmacy Address:		Pharmacy Phone:	
Secondary Pharmacy:	Pharmacy Address:		Pharmacy Phone:	
Emergency Contact:	Relationship:		Contact Phone:	

Marital Status:
☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Other: _____

Appointment Reminders:
☐ Phone Call
☐ Text

Send Notes to PCP:
☐ Yes
☐ No

Race:
☐ American Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White/Caucasian
☐ Declined to Specify

Ethnicity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Declined to Specify

How did you hear about OGA?
☐ Emergency Care/ER ☐ Facebook
☐ Family/Friend ☐ Internet Search
☐ OGA Website ☐ Patient Referral
☐ Provider/Insurance Directory
☐ Referring Physician Office
☐ Yellow pages/phone book
☐ Other:_____

If referred, who is Referring Provider:

☐ _____

Guarantor for Minors (under 18 years old) - Responsible party is parent/guardian bringing patient in each visit

Last Name:	First Name: M.I.		Date of Birth:
Mailing Address:	City:	State:	Zip Code:
Relationship to Patient:	Social Security Number:	Phone:	
Employer:	Employer Address:	Work Phone:	

Primary Insurance		Secondary Insurance	
Insurance Company:	Phone Number:	Insurance Company:	Phone Number:
Claims Address:		Claims Address:	
Policy Number	Group Number	Policy Number	Group Number
Policy holder Name/Relationship:	Policy holder Date of Birth:	Policy holder Name/Relationship:	Policy holder Date of Birth:

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Reason for Today's Visit: _____

Advance Directives

Date Reviewed: _____ ☐ None ☐ DNR ☐ Living Will ☐ Durable Power of Attorney ☐ HC Proxy

Medications ☐ No Medications

List all medications you take, prescription and non-prescription (vitamins, over the counter meds, herbals, etc.) and their dosage:

Medication / Dose	Medication / Dose
1.	5.
2.	6.
3.	7.
4.	8.

(Attach additional pages as necessary)

Allergies ☐ No known allergies

Allergy /Reaction	Allergy / Reaction
1.	5.
2.	6.
3.	7.
4.	8.

Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

☐ Alcohol addiction	____/____/____	☐ Diabetes	____/____/____	☐ Migraines	____/____/____
☐ Allergies	____/____/____	Type: _____		☐ Obesity	____/____/____
☐ Anemia	____/____/____	☐ Emphysema	____/____/____	☐ Osteoporosis	____/____/____
☐ Anxiety	____/____/____	☐ Esophageal reflux	____/____/____	☐ Recurrent UTI	____/____/___
☐ Arthritis	____/____/____	☐ Gall Bladder Disease	____/____/____	☐ Rheumatoid Arthritis	____/____/____
☐ Asthma	____/____/____	Type: _____		☐ Seizures/Epilepsy	____/____/____
☐ Autoimmune Disorder	____/____/____	☐ Hearing Loss	____/____/____	☐ Sleep Apnea	____/____/____
☐ Bleeding Disorder	____/____/____	☐ Heart Disease	____/____/____	☐ Stomach Ulcer	____/____/____
☐ Blood Clots	____/____/____	Type: _____			
☐ Cancer	____/____/____	☐ Hepatitis	____/____/____	☐ Stroke (CVA)	____/____/____
Type: _____		☐ High blood pressure	____/____/____	☐ Tuberculosis	____/____/____
☐ Chronic bronchitis	____/____/____	☐ High cholesterol	____/____/____	☐ Thyroid Disease	____/____/____
☐ Circulatory disease	____/____/____	☐ Irritable bowel syndrome	____/____/____	Type: _____	
☐ COPD	____/____/____	☐ Kidney Disease	____/____/____	☐ Other:	____/____/____
☐ Crohn's Disease	____/____/____	Type: _____		_____	
☐ Depression	____/____/____	☐ Liver Disease	____/____/____	☐ Other:	____/____/____
Post-Partum Depression	____/____/____	☐ Mental Health Disorder	____/____/____	_____	

Gynecological Medical History

Age of First Menstrual Cycle: _____ LMP: _____ Sexually Active ☐ Current ☐ Past ☐ Never

Birth control method: _____ Domestic Violence ☐ Current ☐ Past ☐ Never

Period regular? ☐ Yes ☐ No Period Painful? ☐ Yes ☐ No Heavy Periods? ☐ Yes ☐ No

☐ Bartholin Cyst	___/____/____	☐ Genital Herpes	___/____/____	☐ Ovarian Cyst	____ /____ /____
☐ Breast mass/lump	___/____/____	☐ Histrory of Gonorrhea	___/____/____	☐ Pelvic Inflammatory Disease	____ /____ /____

Patient name: _____ M.R. # _____ PF050

Gynecological Medical History continued

☐ Endometriosis ___/____/____ ☐ History of Chlamydia ___/____/____ ☐ Pelvic Pain ___/____/____
☐ Fibroids ___/____/____ ☐ Infertility ___/____/____
Date of last pap ___/____/____ ☐ Abnomal pap? ☐ Yes ☐ No If yes, date of abnormal pap ____ /____ /____

Obstetric History *(list pregnancies, miscarriages and abortions in order)*

	Year	Type of Delivery	M or F	Weight	Complications
1					
2					
3					
4					
5					
6					

Female Surgical History

	Date		Date		Date
☐ Bilateral Tubal Ligation	___/____/____	☐ Cone Biopsy or LEEP	___/____/____	☐ Hysterectomy (abdominal w/ovaries & tubes removed)	___/____/____
☐ Breast Augmentation	___/____/____	☐ D and C	___/____/____		
☐ Breast Biopsy	___/____/____	☐ D and E	___/____/____	☐ Hysterectomy (abdominal w/o ovaries & tubes removed)	___/____/____
☐ Breast Mastectomy ☐ Right ☐ Left	___/____/____	☐ Endometrial Ablation	___/____/____		
☐ Breast Reduction	___/____/____	☐ Hysteroscopy	___/____/____	☐ Hysterectomy (vaginal w/ovaries & tubes removed)	___/____/____
☐ Colposcopy	___/____/____	☐ Myomectomy	___/____/____		
		☐ Pelvic Sling	___/____/____	☐ Hysterectomy (vaginal w/o ovaries & tubes removed)	___/____/____

Surgical History

☐ Angioplasty	___/____/____	☐ Colectomy	___/____/____	☐ Lumpectomy	___/____/____
☐ Angioplasty w/ stent	___/____/____	☐ Colostomy	___/____/____	☐ Open Reduction	___/____/____
☐ Appendectomy	___/____/____	☐ Gastric bypass	___/____/____	☐ Organ Transplant	___/____/____
☐ Arthroscopy knee	___/____/____	☐ Hernia repair	___/____/____	☐ Pacemaker	___/____/____
☐ Back surgery	___/____/____	☐ Hip replacement	___/____/____	☐ Small bowel resection	___/____/____
☐ Coronary Artery Bypass Graft	___/____/____	☐ Internal Fixation	___/____/____	☐ Thyroidectomy	___/____/____
☐ Carpal tunnel release	___/____/____	☐ Knee replacement	___/____/____	☐ Tonsillectomy	___/____/____
☐ Cataract extraction	___/____/____	☐ LASIK	___/____/____	☐ Wisdom Tooth Removal	___/____/____
☐ Cholecystectomy	___/____/____	☐ Liver Biopsy	___/____/____	☐ Other _____	___/____/____

Family History

Please indicate age of onset for any family member who has/had any of the following conditions and if it was the cause of death.

☐ I am adopted	Mother	Father	Brother/Sister	Grandparent	Children	Cause of Death
☐ Alcoholism				____ Maternal ____ Paternal		☐ Yes ☐ No
☐ Alzheimer's Disease				____ Maternal ____ Paternal		☐ Yes ☐ No
☐ Blood Disease				____ Maternal ____ Paternal		☐ Yes ☐ No
☐ Heart Disease before 50				____ Maternal ____ Paternal		☐ Yes ☐ No
☐ Cancer:_____				____ Maternal ____ Paternal		☐ Yes ☐ No
☐ Depression				____ Maternal ____ Paternal		☐ Yes ☐ No
☐ Developmental delay				____ Maternal ____ Paternal		☐ Yes ☐ No
☐ Diabetes				____ Maternal ____ Paternal		☐ Yes ☐ No
☐ Hearing deficiency				____ Maternal ____ Paternal		☐ Yes ☐ No
☐ High Cholesterol				____ Maternal ____ Paternal		☐ Yes ☐ No
☐ Hypertension				____ Maternal ____ Paternal		☐ Yes ☐ No
☐ Kidney disease				____ Maternal ____ Paternal		☐ Yes ☐ No
☐ Mental illness				____ Maternal ____ Paternal		☐ Yes ☐ No

☐ Migraines				____ Maternal ____ Paternal			☐ Yes ☐ No
☐ Obesity				____ Maternal ____ Paternal			☐ Yes ☐ No
☐ Osteoporosis				____ Maternal ____ Paternal			☐ Yes ☐ No
☐ Seizures/Epilepsy				____ Maternal ____ Paternal			☐ Yes ☐ No
☐ Stroke (CVA)				____ Maternal ____ Paternal			☐ Yes ☐ No

Social History

Have you ever used tobacco? ☐ Yes ☐ Never ☐ Past Use Type of Tobacco? _____

Packs per day? _____ Years smoked? _____ Year Quit? _____

Have you ever vaped? ☐ Yes ☐ Never ☐ Past Use Type of vape product? _____

Puffs/Cartridges per day? _____ Years Vaped? _____ Year Quit? _____

Do you drink alcohol? ☐ Yes ☐ Never ☐ Past Use Year Quit? _____

Type? _____ Frequency: _____ Per ☐ Day ☐ Week ☐ Month ☐ Year

Amount? _____ Last Drink? _____

Do you use illicit drugs? ☐ Yes ☐ Never ☐ Past Use Year Quit? _____

Type? _____ Frequency: _____ Per ☐ Day ☐ Week ☐ Month ☐ Yea

Amount? _____ Last use? _____

Health Maintenance

Please indicate if you have had the following items performed and the date to the best of your knowledge:

			Date of last
Annual / Preventative Exam	☐ Yes	☐ No	____/____/_____
Breast Exam	☐ Yes	☐ No	____/____/_____
Cholesterol	☐ Yes	☐ No	____/____/_____
Colonoscopy	☐ Yes	☐ No	____/____/_____
Covid-19 positive testing	☐ Yes	☐ No	____/____/_____
Covid-19 vaccine	☐ Yes	☐ No	____/____/_____
Dental Exam	☐ Yes	☐ No	____/____/_____
DEXA Scan (Bone Density)	☐ Yes	☐ No	____/____/_____
Eye Exam	☐ Yes	☐ No	____/____/_____
Gardasil / HPV vaccine	☐ Yes	☐ No	____/____/_____
Gyn Exam	☐ Yes	☐ No	____/____/_____
Influenza Vaccine	☐ Yes	☐ No	____/____/_____
Mammogram	☐ Yes	☐ No	____/____/_____
Pneumococcal Vaccine	☐ Yes	☐ No	____/____/_____
Sigmoidoscopy	☐ Yes	☐ No	____/____/_____
Stool cards for hidden blood	☐ Yes	☐ No	____/____/_____
Tetanus Vaccine	☐ Yes	☐ No	____/____/_____
Other vaccine			

I certify the above information is complete, correct and accurate to the best of my ability.

Signature: _____ Date: _____

Office use only:

☐ Provider reviewed Initials: _____ Date:_____

☐ Data keyed in NextGen Initials: _____ Date: _____

Patient name: _____ M.R. # _____ PF050

Patient Notice and Acknowledgement
Late Arrivals, Cancellations, No-Shows, Co-Pays

1. We require 24-hour notice for any appointment cancellation and/or appointment reschedules.

2. OGA Providers will do their best to accommodate any late arrivals and ask you notify our office as soon as you know you will not make the appointment time. Out of respect to your designated appointment time, other patients, and our Providers time we may not always be able to accommodate your late arrival. If you are more than 10 minutes late for an appointment, we may ask you to reschedule.

3. You will be considered a No Show to your appointment if you do not contact our office to cancel or reschedule with at least 24 hours' notice **OR** do not contact us to notify of your late arrival.

4. If you do No-Show your appointment, our Nursing team will attempt to contact you 1 time.

5. If you have no-showed 2 times in a row, you will receive a letter notifying you. If you do not let us know that you want to continue to be an active patient of OGA and have a 3rd no-show in a row, then unfortunately we will need to have you seek care outside OGA.

6. OGA will charge a **$20.00** or the amount of typical **Co-pay**, whichever is less, after the first No-Show for each patient.

7. To ensure you are getting timely communication, our primary way of communication will be through our OGA Patient Portal, if you have an active and valid email address. You will be able to access all reviewed lab results, send messages, and view appointments. Please provide our check-in team with your current email in order to set up your patient portal.

8. We will also communicate appointments through text messages, phone call or email. Please provide the most current information to the check-in team and your first preference for communication on appointments and other key information. You will see message coming from 208-888-0909 so please add that to your "allowed" contact numbers. Text reminders are from 622622.

9. You will be expected to pay any Co-Pays and estimated patient responsibility at time of service.

10. A routine preventive exam (annual/wellness) is technically defined as a periodic comprehensive preventive medical evaluation and management. The routine preventive exam is not meant to evaluate, diagnose or treat existing health problems. These will be scheduled as two separate visits.

I have read and understand OGAs Policies for Late Arrivals, Cancellations, No-Shows, Co-Pays and Patient Portal. I understand that if I do not provide advanced notice of my appointment cancellation, I will be charged $20.00 or the amount of my typical Co-Pay, whichever is less, for each No-Show after the first occurrence. I understand collection of my co-pay and estimated patient responsibility is due at time of service.

Patient Name: _____ Date: _____

Patient Signature: _____

Patient Sticker

Routine Preventive Exams (Annual Physicals)

Many patients have health insurance plans that cover the entire cost of a yearly preventive health care visit, otherwise known as an annual physical. The purpose of this exam is to identify potential health problems in the early stages when they may be easier and less costly to treat.

A routine preventive exam is technically defined as a periodic comprehensive preventive medical evaluation and management and includes the following:

- Past medical, social and family history
- Complete physical exam and review of body systems
- Review of medications and administration of immunizations
- Counseling/anticipatory guidance/risk factor reduction interventions
- Review of age/gender appropriate screening tests
- Review or changes to contraception

The routine preventive exam is not meant to evaluate, diagnose or treat existing health problems.

This exam is prevention-focused rather than problem-focused. That means it is designed to prevent minor issues from becoming serious. It is not meant to evaluate, diagnose or treat existing problems.

If you have an existing problem that needs to be addressed, such as abnormal bleeding, hormones, menopausal symptoms, mood changes, depression or anxiety, changes in libido, vaginal discharge, pelvic pain, high blood pressure, diabetes, skin rash, high cholesterol, headaches, etc., you will need to schedule a separate follow-up appointment on a separate day. These concerns are not part of your annual exam.

Exams relating to the treatment of existing medical conditions would not be billed as routine preventive exam and would apply towards your copay, deductible or co-insurance, which means you may owe a balance.

In addition, some lab tests may not fall under preventive care if they are performed for specific problems or existing conditions that require ongoing oversight. For example, once you have been diagnosed with high cholesterol, a lipid panel is no longer considered screening. Instead, it is considered oversight and management of the disease. Every insurance company has a list of lab services they consider to be screenings. If you need to know what these are, ask your insurance company before you have your labs drawn. OGA must bill all services according to the reason indicated by the provider.

06/2021
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Q: Will my provider only address what my health plan covers for a routine preventive exam?

Not necessarily. Your provider does not know your health plan benefits and sees many patients per day with various types of coverage. You will need to know which services are covered under your health plan. You can find this information by reviewing your Summary of Benefits prior to your preventive exam or by calling member services on your insurance card.

Q: What can I do to make sure I receive 100% coverage of my routine preventive exam?

You can take the following steps to help ensure your routine exam is billed correctly:

1. When scheduling your routine preventive exam, please use the terms “routine preventive exam”, “complete physical exam” or “annual physical”. Do not use terms such as “check-up”, “med check”, or “establish care”. These all imply that the visit is to evaluate a known medical condition.

2. When you talk with your provider, let them know you are there for your routine preventive exam.

3. If you bring up health problems during your routine preventive exam, understand provider may ask that you schedule a separate appointment for evaluation of that problem.

4. Do not save up all your health concerns for your routine preventive exam. If you have a current chronic condition, you may need other diagnostic visits and services during the year.

Q: What do I do if I feel an error has been made on my bill?

Step 1: Call the billing office at **208-955-0350** to ask questions and see if a coding review is warranted.