Associated Valley Obstetrics & Gynecology
Talbot Professional Center 4011 Talbot Rd. S. Suite 430 Renton, WA 98055 Ph 425.656.2496 Fax 425.572.6150

PLEASE READ

LORI D. CHANNELL, M.D.
Board Certified in
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SHELLY LEWIS, M.D.
Board Eligible in
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HAILEY HUNT, M.D.
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Welcome to Associated Valley Obstetrics and Gynecology. In order to provide the best quality care, it is important that you arrive on time for your appointment. Please bring with you the completed paperwork enclosed in this mailing along with your insurance card.

In the event you arrive after your scheduled appointment time, or without your completed paperwork, you will likely be asked to reschedule so as not to disrupt other patients' appointments. Appointments require 48-hour cancellation notice or a $50 missed appointment fee may be assessed.

*Please note: In the event you are scheduled for an ultrasound, our office policy is to limit guests to TWO per patient.

Thank you for the opportunity to care for you.

ASSOCIATED VALLEY OBSTETRICS AND GYNECOLOGY

Talbot Professional Center • 4011 Talbot Road South – Suite 430 • Renton, Washington • (425) 656-2496

PATIENT REGISTRATION

PATIENT NAME_____ TODAY'S DATE_____

Address_____ Home Phone_____

_____ Cell Phone_____

City/State/Zip_____ Work Phone_____

Birthdate_____ Age_____ May we leave messages on your answering machine? _____

Social Security # _____ Sex: Male Female Marital Status: S M W D

Email Address: _____

How did you hear about our office? _____

Were you referred to us by a doctor? Yes No If so, by whom?_____

What is your preferred method for appointment reminders? Text message Email Phone Call

PREFERRED PHARMACY:

Name_____ Address _____City _____ Phone_____

EMPLOYER INFORMATION

PATIENT'S EMPLOYER _____ SPOUSE'S NAME_____

Address _____ Spouse's Employer_____

_____ Spouse's Cell/Hm Phone _____

Occupation _____Spouse's Soc Sec # _____DOB_____

Patient's relationship to person responsible for bill: Self Spouse

INSURANCE INFORMATION

Primary Insurance Name _____ Secondary Insurance Name _____

Subscriber's Name _____ DOB _____ Subscriber's Name _____ DOB _____

ID # _____ Group # _____ ID # _____ Group # _____

Address _____ Address _____

Phone # _____ Phone # _____

Relationship to subscriber: Self Spouse Dependent Child Relationship to subscriber: Self Spouse Dependent Child

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY (PREFERABLY NOT LIVING AT SAME ADDRESS)

Name _____ Relationship to patient _____ DOB _____

Home Phone _____Work Phone _____ Cell Phone _____ Primary: HM WK CELL

ASSIGNMENT AND RELEASE

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I also understand that I will be charged a service charge of 1% per month (12% annually) on any amount outstanding 60 days past due.

SIGNED: _____

AUTHORIZATION OF TREATMENT OF A MINOR: I authorize Valley OB/GYN to treat the minor patient named above. It is our policy that the parent or guardian who requests treatment of a minor be financially responsible for the services rendered.

SIGNED: _____

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Notice of Privacy Practices Acknowledgment

Associated Valley Obstetrics & Gynecology has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact **Tracy Lewis, Administrator** at **(425)251-3454** to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By my signature below, I agree that I have received the Notice of Privacy Practices of Associated Valley Obstetrics & Gynecology.

_____

Printed name of patient

_____

Patient or legally authorized individual's signature Date Time

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record.

May we leave a message on your home recorder? YES_____ NO_____ N/A_____
May we leave a message on your cell voicemail? YES_____ NO_____ N/A_____
May we leave a message with people at your house? YES_____ NO_____ N/A_____
May we discuss your test results with members at your house? YES_____ NO_____ N/A____

Please list family members with whom we may discuss test results, appointments, and your presence at the office:

Name_____

Name_____

For Office Use Only

Office staff complete below:
I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date: _____ Staff member initials: _____

Reasons: _____

_____

Associated Valley Obstetrics & Gynecology

Please inform us of all Insurance Plans you are covered under even if you have Apple Health, Provider One, or DSHS.

Billing Insurance Plans out of order can result in claims being denied or payments being recouped by an Insurance Carrier, and can result in additional patient financial responsibility.

I have informed you of all of the Insurance Plans I am covered under.

Signature:_____

Print Name:_____
Acct #_____

Associated Valley Obstetrics & Gynecology

Today's Date_____

Legal Name_____ Date of Birth_____Age_____
First Middle Last

Phone Numbers: Work_____ Home_____ Cell_____
Social Security Number_____ Email_____ Do you prefer chaperone during exam? Y/N
Reason for today's visit? _____

This information is confidential. It will only be released at your written request.
If you are a minor, we cannot discuss this or your care with your parents without your consent.

Medical History - Have you ever been diagnosed with any of the following? Please circle all that apply.

Alcohol abuse	Depression	High blood pressure	Osteoporosis/Osteopenia
Anxiety	Diabetes	High cholesterol	Polycystic ovarian syndrome
Asthma	Drug abuse	Infertility	Pelvic/hip injury
Bipolar disorder	Epilepsy/seizures	Liver disease	Recurrent UTI
Bleeding disorder	GERD/Peptic ulcer	Lung disease/tuberculosis	Stroke
Bowel disease (IBS/IBD)	Glaucoma	Mental health problems	Thyroid disease
Breast cancer	Hearing problems	Migraine headaches	(hypo/hyper)
Cancer (other)	Heart disease	Multiple sclerosis	Transfusions
	Hepatitis (A/B/C)	Neurological problems	

Other_____

Family Health History - Has anyone in your family including grandparents; parents or siblings ever had the following. Please circle all that apply. Please indicate relationship.

Birth defects	Colon cancer	High blood pressure	Skin cancer
Blood clots in legs/lungs	Diabetes	High cholesterol	Stroke
Breast cancer	Endometriosis	Osteoporosis	Thyroid disease
Cervical cancer	Heart disease	Ovarian cancer	Uterine cancer

Medications and Allergies

Any known drug allergies? Please list allergy and reaction _____
Please list all medications and why you are taking them.

Medication	Reason for medication	Medication	Reason for medication

Any vitamins or natural supplements? _____

Surgery and Hospitalizations - Give year or your age when done.

Appendectomy_____	Cesarean section_____	Gall bladder_____	LEEP/Cervical Cone_____
Blood transfusions_____	D&C_____	Hysterectomy_____	Tonsillectomy_____
Breast surgery _____	Gyn Surgery _____	Laparoscopy_____	Tubal ligation_____

Other hospitalizations_____

Gynecologic History / Immunization History - Please provide dates where appropriate

Last pelvic exam _____ Last pap smear _____
Prior abnormal pap smear ___Yes ____ No / Treatments for abnormal pap smear(s) _____
Have you had the HPV vaccine series? (Gardasil 4 or 9?) ____Yes ___No
Date and place of last mammogram_____
Have your had colon cancer screening (colonoscopy, stool blood test, sigmoidoscopy)? ____Yes ____No
Have you had Genital herpes, Chlamydia, gonorrhea or pelvic inflammatory disease? ____Yes ____No
Do you currently have vaginal itching, odor or abnormal discharge? ____Yes ____No
Have you had your cholesterol checked in the past 3 years? ____Yes ____No

Associated Valley Obstetrics & Gynecology

Menstrual History (if menstruating)

Date of last period_____
How old were you with your first period_____

Do you have painful cramps	___Yes ___No	Do you bleed between periods	___Yes ___No
Do you take medicine for cramps	___Yes ___No	Are your periods prolonged more than nine days	___Yes ___No
Do you have PMS	___Yes ___No	Is heavy flow a problem	___Yes ___No
Was the last period normal for you	___Yes ___No	Do periods/PMS keep you home	___Yes ___No
Do you skip periods	___Yes ___No	Any bleeding after or during sex	___Yes ___No
How many days between periods	_____	How many days do periods typically last	_____

Menopause History (if menopausal)

Do you have hot flashes	___Yes ___No	Have you ever used hormone replacement	___Yes ___No
Do you have vaginal dryness	___Yes ___No	Do you have problems with low sex drive	___Yes ___No
Do you have urinary frequency	___Yes ___No	Do you have loss of urine (incontinence)	___Yes ___No
Have you had a bone density test	___Yes ___No		

Pregnancy History

Date	Type (Vaginal, Cesarean)	Weight	Gender	Anesthesia (epidural, spinal)	Complications

Sexual History (Complete any that apply to you)

Age you started having intercourse_____

Do you have a male partner	___Yes ___No	Do you feel safe in your relationship	___Yes ___No
Do you have a female partner	___Yes ___No	Are you or your partner using birth control	___Yes ___No
Is your sexual activity satisfactory	___Yes ___No	What type_____	
Any pain with intercourse	___Yes ___No	Are you satisfied with your birth control method	___Yes ___No
Do you/partner have other partners?	___Yes ___No	Has your partner had a vasectomy	___Yes ___No
How many partners have you had		Does your partner use a condom consistently	___Yes ___No
Lifetime_____ Last Year_____		Do you need information of safe sex practices	___Yes ___No
Do you wish to have STD testing today	___Yes ___No		

Health Habits

Do you smoke?	___Yes ___No	Do you drink alcohol? ___Yes ___No	
		_____Rarely ____Daily ____Weekly	
Packs per day _____		Do you think you have a problem with alcohol	___Yes ___No
Have you smoked in the past	___Yes ___No	Do you wear seat belts when driving	___Yes ___No
Quit date_____		Do you exercise regularly	___Yes ___No
Do you use street drugs?	___Yes ___No	How many times per week/what type?	
What kind(s)_____		_____	
Have you in the past	___Yes ___No		
IV drug use	___Yes ___No		

Social History

Marital status (circle): Single Married Divorced Widowed Separated Living with
Current occupation_____ Who referred you to our office_____
Who is your primary care physician_____
Other doctors you see _____

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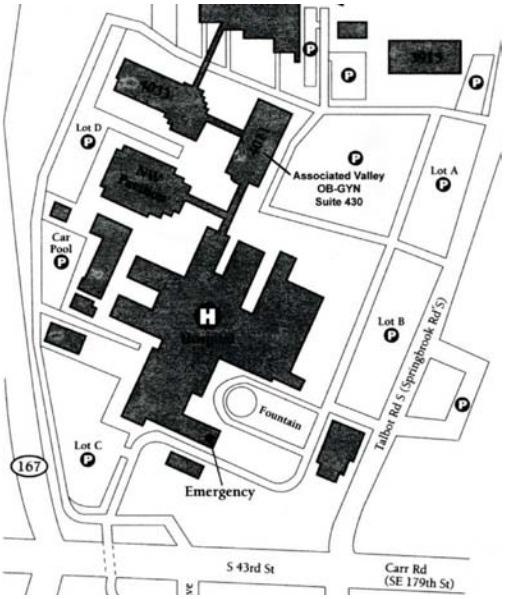
Office Information

Office Hours are Monday through Thursday 9:00AM to 5:00PM,
Friday 9:00AM to 4:00PM.
Office Phone Numbers:

(425) 656-2496
(425) 251-3454 (Business Office)

Location

Associated Valley Obstetrics & Gynecology is conveniently located next to Valley Medical Center.



4011 Talbot Rd. S. – Suite 430
Renton, WA 98055

Directions

Driving north or south on I-5, take the northbound I-405 exit. At Renton, take the southbound Hwy. 167 (Kent/Auburn) exit. From 167, take the first exit (S. 180th), turn left, and on 43rd St. turn left. If you are Northbound on Hwy.167, take the 43rd St. exit, and turn right on 43rd St. Turn left on Talbot Rd. S. We are the second entrance on the left.