JAMES J. DALLA RIVA, MD, FACOG
THOMAS M. HULSEN, MD, FACOG
MONICA E. MAJOR-HARRIS, APRN, FNP-BC
OBSTETRICS & GYNECOLOGY
6812 STATE ROUTE 162, SUITE 301
MARYVILLE, ILLINOIS 62062
618/288-5699 * 618/288-5797 (FAX)

Dear Patient,

Thank you for choosing Dalla Riva and Hulsen Obstetrics and Gynecology for your health care needs. Enclosed you will find registration and history forms for you to fill out and bring with you to your scheduled appointment. These forms are for both new and established patients. Please fill all forms out to the best of your ability. Please check with your insurance company and/or primary care physician prior to your visit if your insurance requires a referral. Please bring your current insurance card along with your copayment to your visit. If you have any questions regarding your insurance coverage, benefits, or copayments, please contact the number on your insurance card prior to your visit.

Please be advised that our office has recently relocated. We are now located in Anderson Hospital Physicians Office Building #2, Suite 301. Our telephone number remains the same.

Thank you,

Karen L Copeland, CPC, RMC

Karen L. Copeland, CPC, RMC
Office Manager

072012

James J. Dalla Riva, MD, FACOG
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6812 State Route 162, Suite 301
Maryville, IL 62062
(618)288-5699 FAX (618)288-5797

GENERAL HISTORY

Name:		Referred By:		Date:
Age:	Date of Birth:		Marital Status:	
Occupation:			Occupation Concerns:	
Blood Type:	Rh Factor:			
Health Habits:	Caffeine:	Tobacco:	Alcohol:	Recreational Drugs:
Date last period began:		Cycle Length:		Duration of bleeding:
Last pap smear:		Normal/Abnormal:		Last Mammogram:

Circle if you have ever had any of the following problems:

Abnormal Pap Smear, Bleeding Between Periods, Breast Lumps, Extreme Menstrual Pain, Hot Flashes,
Nipple Discharge, Painful Intercourse, Vaginal Discharge, or any other problem not listed:
Allergies to Medications of Other Substances:
Chronic Illness:
Hospitalizations/Surgeries (list reason, type of surgery, and date)

PREGNANCY RECORD:

NO.	Month	Year	Name	Birth Weight	Sex	Weeks Pregnant	Hours in Labor	Type of Delivery & Complications

MEDICATIONS

Please list medications you are currently taking:

_____

_____

James J. Dalla Riva, MD, FACOG
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Health History Continued

SYMPTOMS

Please circle symptoms you currently have or have had in the past year.

General- Chills, Depression, Dizziness, Fainting, Fever, Forgetfulness, Headache, Loss of Sleep, Loss of Weight, Nervousness, Numbness, Sweats
Muscle/Joint/Bone(pain, weakness, numbness) – Arms, Back, Feet, Hands, Hips, Legs, Neck, Shoulders
Genito-Urinary – Blood in Urine, Frequent Urination, Lack of Bladder Control, Painful Urination
Gastrointestinal – Appetite Poor, Bloating, Bowl Changes, Constipation, Diarrhea, Excessive Hunger, Excessive Thirst, Gas, Hemorrhoids, Indigestion, Nausea, Rectal Bleeding, Stomach Pain, Vomiting, Vomiting Blood
Cardiovascular – Chest Pain, High Blood Pressure, Irregular Heart Beat, Low Blood Pressure, Poor Circulation, Rapid Heart Beat, Swelling of Ankles, Varicose Veins
Eyes, Ear, Nose, Throat – Bleeding Gums, Difficulty Swallowing, Earache, Ear Discharge, Hay Fever, Hoarseness, Loss of Hearing, Nosebleeds, Persistent Cough, Ringing in Ears, Sinus Problems, Visual Changes
Skin – Easy Bruising, Hives, Itching, Changes in Moles, Rash Scars, Sores

CONDITIONS

Please circle conditions you have or have had in the past.

AIDS, Alcoholism, Anemia, Anorexia, Appendicitis, Arthritis, Asthma, Bleeding Disorders, Breast Lump, Bronchitis, Bulimia, Cancer, Cataracts, Chemical Dependency, Chicken Pox, Diabetes, Emphysema, Epilepsy, Glaucoma, Goiter, Gonorrhea, Gout, Heart Disease, Hepatitis, Hernia, Herpes, High Cholesterol, HIV Positive, Kidney Disease, Liver Disease, Measles, Migraine Headaches, Miscarriage, Mononucleosis, Multiple Sclerosis, Mumps, Pacemaker, Pneumonia, Polio, Psychiatric Care, Rheumatic Fever, Scarlet Fever, Stroke, Suicide Attempt, Thyroid Problems, Tonsillitis, Tuberculosis, Typhoid Fever, Ulcers, Vaginal Infections, Venereal Disease

FAMILY HISTORY

Fill in the health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Sisters				
Brothers				

Please circle and list relationship to you if your blood relatives had any of the following:

Arthritis, Gout_____

Asthma, Hay Fever_____

Cancer_____

Chemical Dependency_____

Diabetes_____

Heart Disease, Strokes_____

High Blood Pressure_____

Kidney Disease_____

Tuberculosis_____

Other disease not listed_____

Osteoporosis_____

_____

JAMES J. DALLA RIVA, MD, FACOG * THOMAS M. HULSEN, MD, FACOG

PATIENT REGISTRATION INFORMATION

So we may accurately file claims to your insurance company, please fill in ALL blanks. Please present insurance cards to the Receptionist upon arrival.

Today's Date_____ Referred By_____

Primary Care Physician_____

Name_____
(First) (Middle) (Last)

Address_____
(Street) (City) (State) (Zip Code)

Home Phone Number_____ Cell Phone Number_____

Marital Status: M S W D Date of Birth_____ Age_____

Social Security #_____ Drivers License #_____

Patient's Employer or School_____

Employer's Address_____ Phone Number_____

Full Time/Part Time/Temporary_____ Occupation_____

GUARANTOR INFORMATION (Who Insurance is through)

Spouse/Parent Name_____

Address_____

Phone Number_____ Date of Birth_____ SS#_____

Spouse/Parent Employer_____

Address_____ Phone Number_____

INSURANCE INFORMATION

Primary Insurance_____ Subscriber Name_____

ID Number_____ Group Number_____

Secondary Insurance_____ Subscriber Name_____

ID Number_____ Group Number_____

EMERGENCY CONTACT

Name_____ Home Phone Number_____

Address_____ Work/Cell Phone Number_____

JAMES J. DALLA RIVA, M.D., F.A.C.O.G.
THOMAS M. HULSEN, M.D., F.A.C.O.G.

FINANCIAL POLICY

(Please read and sign where indicated)

I, the undersigned, have insurance coverage with _____ and assign directly to James J. Dalla Riva, MD all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronically. I hereby recognize and accept full responsibility for the timely payment of any balances remaining after such benefits have been paid. I have read and I understand this policy and the financial policy of this office.

_____ _____

SIGNATURE DATE

MEDICARE PATIENTS

(Please read and sign where indicated)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to James J. Dalla Riva, MD/Thomas M. Hulsen for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charged determination of the Medicare carrier.

_____ _____

SIGNATURE DATE

DALLA RIVA OBSTETRICS & GYNECOLOGY
James J. Dalla Riva, M.D., F.A.C.O.G.
Thomas M. Hulsen, M.D., F.A.C.O.G.

PAYMENT POLICY

Thank you for choosing us as your ob/gyn providers. We are committed to providing you with quality and affordable health care. Please carefully read our payment policy. After reading this policy, please ask any questions you may have, and sign in the space provided. A copy of this policy will be provided to you upon request.

1. **Self-pay.** Please be aware that you will be responsible to pay the amount due at the time of service. Before seeing the provider, make sure you have the available funds with you to pay for the services provided. If you need an estimated cost, please ask to speak to our billing department prior to your visit. We accept cash, personal check, visa and MasterCard.
2. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate in but do not have an up-to-date insurance card, payment in full for each visit is required until we receive your up-to-date insurance card. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
3. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
4. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit unless other arrangements are made with our billing department.
5. **Proof of insurance.** All patients must complete our patient information form before seeing the provider. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for the balance.
6. **Claim submission.** We will submit your claims and assist you in any way we reasonable can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and the insurance company.
7. **Coverage changes.** If your insurance company changes, please notify us before your next visit. If you fail to inform us of the change, you will be responsible for the bill.

(OVER)

8. **Nonpayment.** If your account is over 90 days past due, you may receive a letter stating you have 20 days to pay your balance. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. We may also discharge you as a patient from this practice. If this is to occur, we will notify you by mail that you have 30 days to find an alternate medical provider. During that 30-day period, our providers will only be available to treat you on an emergency basis.
9. **Missed Appointments.** Our policy is to charge for missed appointments not canceled within a reasonable timeframe. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature Date

_____

Witness

James J. Dalla Riva, MD, FACOG
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Monica E. Major-Harris, APRN, FNP-BC

6812 State Route 162, Suite 301
Maryville, IL 62062
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f: 618.288.5797

Dear Patient:

At DallaRiva and Hulsen OBGYN, we pride ourselves on offering our patients the most advanced preventative care available. As of August 2012, in accordance with the recommendations of the American College of Obstetrics and Gynecology and the American Society For Colposcopy and Cervical Pathology, we will be performing the following tests as part of our annual well woman visits:

Age 21 – 25
Pap Smear
Chlamydia/Gonorrhea Screening
If Pap is Abnormal – High Risk HPV Testing

Age 26 – 29
Pap Smear
If Pap is Abnormal – High Risk HPV Testing

Age 30 – 64
Pap Smear
High Risk HPV Testing
If Pap is Normal and HPV is Positive – Testing For HPV Types 16/18

HPV Testing in conjunction with a Pap Test for cervical cancer screening, can show with nearly 100% certainty that you do not have cervical cancer. Here are a few things to know about cervical cancer screening:

- Most women will have HPV at some point during their lives but very few will develop cervical cancer
- Cervical cancer develops if an HPV infection persists for many years
- The Pap test looks for abnormal cell changes on the cervix that occur as a result of a persistent high- risk HPV infection. The HPV test looks for HPV infection.
- Women who test negative for high-risk HPV, and have a normal Pap test, have virtually no risk of developing cervical cancer before their next scheduled visit.
- Knowing your HPV status helps you and your provider determine how often you should be screened. Early detection of pre-cancerous cell changes is the key to preventing cervical cancer.
- Your HPV status is not a reliable indicator of you or your partner's sexual behavior. HPV can lie dormant in cervical cells for many years before becoming an active infection.

Most insurance companies pay for HPV testing in women 30 and older. If yours does not, you may receive a bill from the Lab. If you do not want any of the testing listed above, please speak with your provider at your next well woman visit. Thank you and we look forward to seeing you soon.

www.DallaRivaMedical.com

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____
Date of Birth: _____ Date completed: _____

Instructions: Please circle Y to those that apply to YOU and/or YOUR FAMILY (on both your **mother's or father's side**). Behind each statement, please list the relationship to you of the individual diagnosed. You and the following family members should be considered: mother, father, brother, sister, children, maternal/paternal aunts and uncles, nieces, nephews, first cousins, maternal/paternal grandparents and their **age at diagnosis**. This is a screening tool for the common features of hereditary cancer syndromes.

			RELATIONSHIP	AGE AT DIAGNOSIS
BREAST AND OVARIAN CANCER				
Y	N	- Breast cancer at any age		
Y	N	- Ovarian cancer at any age		
Y	N	- Breast cancer in both breasts or multiple primary breast cancers		
Y	N	- Both breast & ovarian cancer		
Y	N	- Pancreatic cancer with breast or ovarian cancer		
Y	N	- Male breast cancer		
Y	N	- 2 or more breast or ovarian cancers (in an individual or a family)		
Y	N	- Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer		
Y	N	Triple negative breast cancer (ER-, PR-, HER2-)		
COLON AND UTERINE CANCER				
Y	N	- Uterine cancer before age 60		
Y	N	- Colorectal cancer before age 60		
Y	N	- Both uterine & colorectal cancer (in an individual or family)		
Y	N	- 2 or more uterine or colorectal cancers (in an individual or a family)		
Y	N	- Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer (in an individual or family)		
Y	N	- 10 or more colon polyps found in a lifetime		
Y	N	- Have you or a family member ever been tested for hereditary cancer syndromes?		

☐ Candidate for further risk assessment and/or genetic testing	☐ Patient offered genetic testing
☐ Information given to patient to review	☐ **Accepted** ☐ **Declined**
☐ Follow up appointment scheduled Date: _____	☐ Not a Candidate for genetic testing

_____ _____

Patient's Signature Date Health Care Provider's Signature Date