James J. Dalla Riva, MD, FACOG
Thomas M. Hulsen, MD, FACOG
Obstetrics & Gynecology
6812 State Route 162, Suite 301
Maryville, Illinois 62062
618/288-5699*618/288-5797 (FAX)

GENERAL HISTORY

Name:	Referred By:	Date:
Age: Date of Birth:	Marital Status:	
Occupation:	Occupation Concerns:	
Covid Vaccinated: Yes / No	Last Covid Booster:	Current Gender Identity:
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:

Note 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 - **DO NOT LEAVE BLANK**:

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
Thomas M. Hulsen, MD, FACOG

SYMPTOMS

Please check 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 - Poor Appetite☐, Bloating☐, Bowel 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, Ears, Nose, Throat - Bleeding Gums☐, Difficulty Swallowing☐, Earache☐, Ear Discharge☐, Hay Fever☐, Hoarseness☐, Loss of Hearing☐, Nosebleeds☐, Persistent Cough☐, Ringing in Ears☐, Sinus Problem☐, Visual Changes☐

Skin - Easy Bruising☐, Hives, Itching☐, Changes in Moles☐, Rash Scars☐, Sores☐

CONDITIONS

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

AIDS☐, Alcoholism☐, Anemia☐, Anorexia☐, Appendicitis☐, Arthritis☐, Asthma☐, Bleeding Disorder☐, 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 check and list relationship to you if your blood relatives had any of the following:

Arthritis☐, Gout☐ ______________________

Cancer☐ ______________________

Diabetes☐ ______________________

High Blood Pressure☐ ______________________

Tuberculosis☐ ______________________

Osteoporosis☐ ______________________

Asthma☐, Hay Fever☐ ______________________

Chemical Dependency ☐ ______________________

Heart Disease, Strokes☐ ______________________

Kidney Disease☐ ______________________

Other disease not listed☐ ______________________

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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 ____________________

Email Address ____

Marital Status: M☐ S☐ W☐ D☐ Date of Birth ______________________ Age __________

Social Security # ________________________ Driver's 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, MD, FACOG
THOMAS M. HULSEN, MD, FACOG

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, MD 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 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 non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____ ______________________

SIGNATURE **DATE**

JAMES J. DALLA RIVA, MD, FACOG
THOMAS M. HULSEN, MD, FACOG
6812 State Route 162, Suite 301
Maryville, Illinois 62062
618/288-5699*618/288-5797 (FAX)

To Whom It May Concern:

I, ________________________________, give Dalla Riva and Hulsen, OB/GYN office personnel permission to release medical information to the following:

Person's Name   Phone #

____

____

____

____

This permission is in effect until I rescind same.

______________________________   ______________
Patient's Signature   Date

* I have received/declined a copy of the HIPAA informational packet.

______________________________   ______________
Patient's Signature   Date

* If we are unable to reach you, and you are ok with us leaving you a detailed voicemail, on your phone, please sign below.

______________________________   ______________
Patient's Signature   Date

DALLA RIVA OBSTETRICS & GYNECOLOGY
James J. Dalla Riva, MD, FACOG
Thomas M. Hulsen, MD, FACOG

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 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 with 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 with 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 reasonably 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 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.

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 time frame. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping you scheduled appointments. Our practice is committed to providing the best treatment to our patients.

10. Our office only accepts Medicaid/Commercial Medicaid plans if they are the only insurance you have. If you have any other insurance, other than Medicaid, the other insurance is automatically primary. If you present us a Medicaid/Commercial Medicaid Card only, you are telling us, this is the only insurance you have. If Medicaid comes back and denies your services due to a different primary insurance, **YOU WILL BE RESPONSIBLE FOR THE FULL AMOUNT**.

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 ______________________________________