****

**WASILLA**

3066 E Meridian Park Loop, Ste. 101 **⏐** Wasilla, AK 99654

(907)277-9700 **[P]** **⏐** (907)258-8010 **[F]**

**ANCHORAGE**

2751 DeBarr Road, Bldg. B, Ste. 310 **⏐** Anchorage, AK 99508

(907)277-9700 **[P]** **⏐** (907)258-8010 **[F]**

**Patient Demographics**

Patient Name (***First / MI / Last***): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: ***Male / Female*** Relationship Status: ***Single / Married / Separated / Divorced / Widowed***

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party**

* Check box if you are the responsible party, and do not fill out the information below.

Patient Name (***First / MI / Last***): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: ***Male / Female*** Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Primary #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

* Check box if you are a private-pay patient.

Primary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (***Parent/Legal Guardian if patient is a minor***) Date

**HIPAA Acknowledgement and Consent**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ acknowledge that I have been provided the HIPAA Notice of Privacy Practices by ***Surgical Specialists of Alaska***. I acknowledge that the HIPAA Notice of Privacy Practices describes the use and disclosure of my protected health information (PHI), and identifies my rights and the duties of which ***Surgical Specialists of Alaska*** must uphold.

**Please initial the following:**

\_\_\_\_\_ Use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare

operations (TPO).

\_\_\_\_\_ Call my home or other designated locations to speak in person or leave a voice message about any items that assist

the practice in carrying out TPO. Including, but not limited to: appointment reminders, insurance items, my clinical

care, and laboratory and diagnostic results.

\_\_\_\_\_ Send mail to my home or other designated location any items that assist the practice in carrying out TPO.

Including, but not limited to: appointment reminders, patient statements, and insurance items.

\_\_\_\_\_ I have the right to request that ***Surgical Specialists of Alaska*** restrict how my PHI is used and/or disclosed to

carry out TPO. However, the practice is not required to agree with my requested restriction, but if they do, they are

bound to this agreement.

\_\_\_\_\_ I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance

upon my prior consent. If I do not sign this consent, ***Surgical Specialists of Alaska*** may decline to provide

treatment to me.

I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information to be released to the following:

Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Family or Friends: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] *Information is not to be released to anyone*

I authorize ***Surgical Specialists of Alaska*** to leave voice messages if I am not available to take a phone call:

[ ] Home [ ] Cell [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] You may leave a detailed message

[ ] You may leave a message asking me to return your call

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (***Parent/Legal Guardian if patient is a minor***) Date

Please note that this will expire one year from date of signature.

**Financial Policies**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am responsible for the payment of all charges associated with my visit. As a courtesy, and for my convenience, ***Surgical Specialists of Alaska*** will bill my insurance company when I have provided my insurance information. I am responsible for deductibles, co-payments, co-insurances, and uncovered services at the time services are rendered. I am responsible for contacting my insurance carrier if I am unsure of my coverage. If the insurance payment is not received within 60 days of billed charges, I am immediately responsible for the full account balance.

**Review and initial the following:**

\_\_\_\_\_ All co-payments, deductibles, and/or co-insurance are due at the time of service.

\_\_\_\_\_ If proof of insurance cannot be provided, patient will be deemed “self-pay”, and payment will be due in full at the time

of service.

\_\_\_\_\_ Private insurance is a contract between you and your insurance company. ***Surgical Specialists of Alaska*** will not

be involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges,

secondary insurance, “usual and customary” charges, etc. ***Surgical Specialists of Alaska*** will supply factual

information as necessary.

\_\_\_\_\_ If the patient is a minor, in the case of separation or divorce, the parent bringing the minor in for their appointment is

responsible to pay for services.

\_\_\_\_\_ Any balances on your account must be paid in full before you will be seen again, unless payment arrangements have

been made with the billing department.

\_\_\_\_\_ If you are here for a wellness visit/physical and have other health problems you wish to discuss with your provider

during this time, additional charges may be applied. Please note that these charges may or may not be covered by

your insurance. If you would like to update the reason for your visit, please see the front desk.

\_\_\_\_\_ Accounts with a balance of $10 or less will not generate a statement. Please refer to your insurance explanation of

benefits (EOB) to see if you owe a balance.

\_\_\_\_\_ A fee of $35 will be charged to the patient for any returned checks marked for NSF. The patients account will be

flagged until the debt has been paid. Payment must be made by cash, credit card, or money order.

\_\_\_\_\_ Methods of payment accepted: cash, personal checks, Visa, and MasterCard.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (***Parent/Legal Guardian if patient is a minor***) Date

**Medical History Questionnaire**

**INSTRUCTIONS:** *Complete the following to the best of your knowledge. Make sure to read each question thoroughly and let the Staff know if you need any assistance with understanding these forms. Thorough completion of this information will help us to better assist you with your care.*

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHIEF COMPLAINT**

Main reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of injury/ onset of symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain how the injury occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* NO
* YES

Is this injury work related?

* CONSTANT
* FREQUENT
* OCCASIONAL

Pain is:

Pain feels like:

* ACHING
* DULL
* SHARP

What makes the pain worse or better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have pain at night or while resting?

* NO
* YES
* NO
* YES

Do you have numbness or tingling? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* NO
* YES

Do you have radiating pain? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Back, Hip & Knee Complaints Only:**

Where does it hurt when you walk? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* NO
* YES

Does your knee lock or catch?

On a scale of 1 to 10 (10 being the most pain), circle your pain level: **0 1 2 3 4 5 6 7 8 9 10**

**CURRENT TREATMENT**

Treatment for chief complaint:

* MEDICATIONS
* INJECTIONS
* PHYSICAL THERAPY
* SPLINTING / BRACING

Diagnostic Studies:

* CT SCAN
* EMG / NCV STUDY
* X-RAYS
* MRI

**PAIN CONTRACT**

* INTHEPAST
* NO
* YES

**MEDICATIONS**

If you are you currently taking any prescription and/or non-prescription medications including aspirin, steroids, vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, herbal remedies, and cold medications please list them below. Be sure to include the frequency and dosage.

* Check box if you do not take any prescription or over the counter medications.
* Check box if you brought a list of your medications (please give it to the Medical Assistant to make a copy).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**

* NONE

Including medications, please indicate any allergies and reaction below. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMUNIZATIONS**

* Check box if you are unaware of immunization history.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Year** |
| Polio |  |  |  |
| Tetanus (TD) |  |  |  |
| Tetanus [w/Pertussis] (TDAP) |  |  |  |
| Tuberculin (TB) |  |  |  |
| Varicella (Chicken Pox) |  |  |  |
| Zostavax (Shingles) |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Year** |
| Hepatitus A |  |  |  |
| Hepatitus B |  |  |  |
| HPV |  |  |  |
| Influenza (flu shot) |  |  |  |
| Meningitis |  |  |  |
| MMR (measles, mumps, rubella) |  |  |  |
| Pneumovax (pneumonia) |  |  |  |

**SOCIAL HISTORY**

**Current Living Arrangement**

* Alone
* Family
* Friends
* Roommate

**Marital Status**

* Single
* Engaged
* Separated
* Divorced
* Domestic Partnership

**Exercise**

* Regularly
* Sometimes
* Never

**Current Employment Status**

* Employed
* Retired
* Unemployed
* Homemaker

Current occupation(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies & Recreational Activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HABITS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Type** | **Frequency** |
| Caffeine |  |  |  |  |
| Cigarettes / Tobacco |  |  |  |  |
| Alcohol |  |  |  |  |
| Recreational / Street Drugs |  |  |  |  |

**REVIEW OF SYSTEMS**

Check all that currently apply.

* Check box if nothing below applies to you.

**ENDOCRINE**

* Cold Intolerance
* Sweating
* Thirst

**EARS**

* Decreased Hearing
* Drainage
* Earache
* Ringing

**CONSTITUTIONAL**

* Fatigue
* Fever or Chills
* Trouble Sleeping
* Weakness
* Weight Loss or Gain

**CARDIOVASCUALR**

* Chest Pain or Discomfort
* Chest Tightness
* Heart Palpitations
* Shortness of Breath
* Swelling

**HEMATOLOGIC**

* Ease of Bleeding
* Ease of Bruising

**HEAD & NECK**

* Headache
* Head Injury
* Migraine
* Neck Pain or Stiffness
* Lumps
* Swollen Glands

**GASTROINTESTINAL**

* Change in Appetite
* Change in Bowel Habits
* Constipation
* Diarrhea
* Difficulty Swallowing
* Heartburn
* Nausea or Vomiting
* Rectal Bleeding

**EYES**

* Cataracts
* Contacts or Glasses
* Blurry or Double Vision
* Flashes of Light
* Floating Specks
* Glaucoma
* Pain
* Redness or Irritation

**NEUROLOGICAL**

* Dizziness
* Fainting
* Numbness
* Seizures
* Tingling
* Tremors

**PSYCHIATRIC**

* Anxiety
* Depression
* Memory Loss
* Nervousness

**NOSE**

* Discharge
* Itching
* Nosebleeds
* Sinus Pain
* Stuffiness

**MUSCULOSKELETAL**

* Back Pain
* Muscle or Joint Pain
* Redness of Joint Area
* Stiffness
* Swelling of Joint Area
* Trauma

**RESPIRATORY**

* Cough
* Coughing up Blood
* Painful Breathing
* Shortness of Breath
* Sputum
* Wheezing

**URINARY**

* Blood in Urine
* Burning or Pain
* Frequency
* Incontinence
* Urgency

**THROAT**

* Bleeding
* Dry Mouth
* Hoarseness
* Non-healing Sores
* Sore Throat
* Sore Tongue
* Thrush

**SKIN**

* Color Changes
* Dryness
* Itching
* Lumps
* Rashes

**VASCULAR**

* Leg Cramping
* Calf Pain

List any other medical conditions below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGERIES & PROCEDURES**

List all previous broken bones/fractures, injuries, and procedures/surgeries. Please include dates of each incident.

* Check box if nothing applies to you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

If the following applies to one or more of your family members, please indicate:

* Check box if you are adopted and/or do **not** know your family history. Skip this section.
* Check box if nothing below applies.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Diseases & Conditions | Mother | Father | Sister(s) | Brother(s) | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | Daughter(s) | Son(s) |
| Alcoholism / Drug Abuse |  |  |  |  |  |  |  |  |  |  |
| Anxiety / Depression |  |  |  |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |  |  |  |
| Asthma / Allergies |  |  |  |  |  |  |  |  |  |  |
| Autoimmune Disease |  |  |  |  |  |  |  |  |  |  |
| Cancer (Specify) |  |  |  |  |  |  |  |  |  |  |
| Diabetes (Type 1 or 2) |  |  |  |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |  |  |  |  |
| Thyroid Disorder |  |  |  |  |  |  |  |  |  |  |

List any other health issues that run in your family below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (***Parent/Legal Guardian if patient is a minor***) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed for Completion By Date



**WASILLA**

3066 E Meridian Park Loop, Ste. 101 **⏐** Wasilla, AK 99654

(907)277-9700 **[P]** **⏐** (907)258-8010 **[F]**

**ANCHORAGE**

2751 DeBarr Road, Bldg. B, Ste. 310 **⏐** Anchorage, AK 99508

(907)277-9700 **[P]** **⏐** (907)258-8010 **[F]**

**Release of Information**

**Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby authorize:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME PHONE FAX

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS CITY / STATE / ZIP

**To release my medical and health information to:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME PHONE FAX

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS CITY / STATE / ZIP

**The following items MUST be initialed to be included in the use or disclosure of other health information:**

\_\_\_\_\_ HIV/AIDS related health information and/or records

\_\_\_\_\_ Mental health information and/or records

\_\_\_\_\_ Genetic testing information and/or records

\_\_\_\_\_ Drug/alcohol diagnosis, treatment and/or referral

information (Federal regulations require a

description of how much and what kind of

information is to be disclosed. Federal law prohibits

the re-disclosure of such information.)

\_\_\_\_\_ **Psychotherapy notes** (If this authorization is for the

use and/or disclosure of psychotherapy notes, then

it cannot be combined with any other

authorization.)

**By *initialing* the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:**

\_\_\_\_ Entire Medical Record \_\_\_\_ Office Chart Notes \_\_\_\_ Operative Reports \_\_\_\_ Laboratory Reports \_\_\_\_ Pathology Reports \_\_\_\_ Imaging/X-ray Reports

\_\_\_\_ ER and Urgent Care Record

\_\_\_\_ All Hospital Records

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Signature (Legal Representative’s Signature if applicable) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Legal Representative (if applicable) Relationship to Patient

*\*I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.*