Alaska Trauma & Acute Care Surgery, LLC

3220 Providence Drive, Suite E3080
Anchorage, Alaska 99508-6907
Ph: 907.375.8785
Fax: 907.375.8788

PATIENT INFORMATION

Patient Last Name: _____ First Name: _____ M.I.: ____

Physical Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City _____ State: _____ Zip: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M / F

Employer: _____ Occupation: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Other Spouse / Significant Other Name: _____

Preferred Pharmacy & Location: _____ Preferred Hospital: _____

Referring Physician: _____ Primary Care Provider (If Different): _____

Home Telephone: _____ □ Leave detailed message □ Leave call back number only

Work Telephone: _____ □ Leave detailed message □ Leave call back number only

Cell Telephone: _____ □ Leave detailed message □ Leave call back number only

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

ID Number: _____ Group: _____

Subscriber Name (If Different): _____

Subscriber Employer: _____

D.O.B.: _____ Patient Relationship to Insured: _____

Secondary Insurance: _____

ID Number: _____ Group: _____

Subscriber Name (If Different): _____

Subscriber Employer: _____

D.O.B.: _____ Patient Relationship to Insured: _____

All Patients: 18 years and older must present with valid photo identification. Children under the age of 18 must have a parent or legal guardian present during their appointment. By signing below, I give my consent for examination, and the performance of any necessary tests and/or procedures. If patient is a minor: As the above patient's legal guardian, I give consent for examination and treatment, to include necessary tests and/or procedures.

I authorize release of any information necessary to process my insurance claims, and assign/request payment to be made directly to the provider(s). I understand that I may revoke this consent at any time in writing to this office. I further understand that I am responsible for payment for all services rendered to me, or any patient for which I am listed as the responsible billing party.

_____ _____ _____

Patient Signature or legal guardian If guardian- Relationship Date

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PATIENT MEDICAL HISTORY

THESE QUESTIONS, THOUGH THEY MAY NOT SEEM RELATED TO YOUR PRESENT CONDITION, CAN AND WILL HELP US TAKE BETTER CARE OF YOU WHEN PLANNING ANY NEEDED SURGICAL PROCEDURES. THANK YOU FOR YOUR COOPERATION IN FILLING OUT THIS FORM.

PAST MEDICAL HISTORY: Have you had any of the following operations? **Give the date.**

C- Section (females) No____ Yes_____
Deliveries (how many) No____ Yes_____
D & C (females) No____ Yes_____
Hysterectomy (females) No____ Yes_____
Prostate Surgery (males) No____ Yes_____
Appendectomy No____ Yes_____
Breast Surgery No____ Yes_____
Colon Surgery No____ Yes_____
Extraction of Teeth No____ Yes_____
Eye Surgery No____ Yes_____
Gallbladder Surgery No____ Yes_____
Heart Surgery No____ Yes_____
Hemorrhoid Surgery No____ Yes_____
Hernia Repair No____ Yes_____
Kidney Surg/Disease No____ Yes_____
Knee Surgery No____ Yes_____
Lung Surgery No____ Yes_____
Nose Surgery No____ Yes_____
Skin Surgery/Disease No____ Yes_____
Tonsils & Adenoids No____ Yes_____
Tumor Surgery No____ Yes_____
Cosmetic Surgery No____ Yes_____
Other Surgery_____

Have you had any complications, unusual bleeding, or scarring following a surgery or injury?

_____

Did you have a normal recovery following any previous surgery?

_____

Have you ever had any complications with anesthesia during or after surgery?

_____

Were the complications resolved?

_____

Have you had a mammogram? _____
Date? _____
Do you do self-breast exams? _____
How often? _____
Have you ever had a blood transfusion of whole blood or blood products?

_____

Who is your regular medical physician?

_____

When was your last physical exam?

_____

By whom?

_____

List all MEDICATIONS and DOSES
(Include aspirin, insulin, birth control, vitamins, natural supplements as well as prescriptions)

_____
_____
_____
_____
_____

(Attach any list you might have)

ALLERGIES: Have you ever had reactions to the following:

Adhesive tape No___ Yes____
Antibiotics (Penicillin, Sulfa, Mycins) No___ Yes____
Betadine No___ Yes____
Etadyne No___ Yes____
Codeine No___ Yes____
Compazine No___ Yes____
Darvon No___ Yes____
Demerol No___ Yes____
Dilaudid No___ Yes____
Empirin No___ Yes____
X-ray dye/contrast No___ Yes____
Local anesthetics No___ Yes____
Metals No___ Yes____
Morphine No___ Yes____
Aspirin No___ Yes____
Other medications (List) No___ Yes____

_____

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REVIEW OF SYSTEMS:

Head, Ears, Nose & Throat

Any head or sinus cold symptoms? No___ Yes____
Have you had any visual changes? No___ Yes____
Any recent illness? No___ Yes____

Pulmonary

Have you had shortness of breath? No___ Yes____
Shortness of breath with activity? No___ Yes____
Do you have asthma? No___ Yes____
Have you been wheezing? No___ Yes____
Have any chronic lung condition? No___ Yes____

Cardiology

Experience recurrent chest pain? No___ Yes____
Has your heart skipped any beats? No___ Yes____
Have you had a rapid heart rate? No___ Yes____
Have heart murmur? No___ Yes____
Have other heart problems? No___ Yes____
Have high blood pressure? No___ Yes____

Gastrointestinal

Have you had any nausea? No___ Yes____
Have you vomited? No___ Yes____
Have you vomited blood? No___ Yes____
Have you had dark/tarry stools? No___ Yes____

Genitourinary

Is urinating painful? No___ Yes____
Do you urinate frequently? No___ Yes____
Do you urinate frequently at night? No___ Yes____

Endocrine

While eating do you find yourself having a hot or cold intolerance? No___ Yes____
Do you have unusual thirst? No___ Yes____

Musculoskeletal

Do you experience bone pain? No___ Yes____
Do you experience joint pain? No___ Yes____

Skin/Breast

Have a rash/skin abnormality? No___ Yes____
Have you noticed any breast lumps? No___ Yes____
Have any chronic skin condition? No___ Yes____

Neurologic:

Have frequent headaches? No___ Yes____
Have you felt dizzy? No___ Yes____
Have you experienced seizures? No___ Yes____

Psychiatric

Are you depressed? No___ Yes____
Do you have anxiety? No___ Yes____
Have you ever been under the care of a psychiatrist or psychologist? No___ Yes___

Hematologic

Any bleeding? No___ Yes____
Any unusual bruising? No___ Yes____

Constitutional

Fevers/Chills/Sweats? No___ Yes____
Night sweats? No___ Yes____
Change in weight? No___ Yes____

SOCIAL HISTORY:

Do you drink more than 6 cups of coffee, tea, cola or drinks with caffeine daily? No___ Yes____
Do you take addicting drugs? No___ Yes____
Have you ever used "street drugs"? No___ Yes____
Have you ever smoked in the past? No___ Yes____
If yes, for how many years? _____ # packs/day_____
Do you smoke now? No___ Yes____
How many packs per day? _____
Age/date you quit smoking_____
Do you drink 2> alcoholic drinks per day? No_ Yes_
Have you ever had tuberculosis? No___ Yes____
Do you have, or have you ever had, venereal disease or AIDS? No___ Yes_____
Have you ever been exposed to the HIV virus? No___ Yes_____

IS THERE ANY HISTORY OF THE FOLLOWING CONDITIONS IN <u>YOUR FAMILY</u>?

			IF SO, WHO?
Allergies	No___	Yes____	Who_____
Asthma	No___	Yes____	Who_____
Emphysema	No___	Yes____	Who_____
Bleeding tendencies	No___	Yes____	Who_____
Cancer	No___	Yes____	Who_____
Diabetes	No___	Yes____	Who_____
Heart Attack	No___	Yes____	Who_____
High Blood Pressure	No___	Yes____	Who_____
Depression/psychiatric problems	No___	Yes____	Who_____
Gallbladder disease	No___	Yes____	Who_____
Hernia	No___	Yes____	Who_____
Problems with anesthesia	No___	Yes____	Who_____
Stroke	No___	Yes____	Who_____
Tuberculosis	No___	Yes____	Who_____

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ATACS Financial Policy

We are dedicated to providing the best possible care and customer service for you. We want you to understand our financial policy so that we can work collaboratively to achieve reimbursement for services we rendered for you.

- Payment on services billed to an insurance carrier will be due 60 days from the date the claim was submitted to the insurance carrier listed on the billing information provided by the Hospital. We file claims with insurers within a week of providing services to you.
- Patients without insurance will be billed directly and are required to pay the balance on their account.
- We do not charge interest on accounts but we expect accounts to be paid within a year of the initial service provided. For your convenience, we accept Visa and MasterCard. We recognize that accounts with exceptionally large balances may require an extended payment period. Please contact our billing office for further details and to set up your payment plan. Note that once we agree to a payment plan, you have committed to make monthly payments. *We reserve the right to send your account to collections without notice if you miss a payment without communicating with our office.*
- Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim. If you have more than one insurance plan, be sure we know who they are; we will file secondary and tertiary insurance claims for you if notified promptly. If your insurance company does not pay the claim by 90 days of the submission date, we will look to you for payment. If we receive a payment from your insurer resolving your account creating an overpayment we will refund you any amount you have paid us.
- We expect that if you have a co-pay or deductible that you will make payment on that amount upon receipt of the billing statement.
- Not all insurance plans cover all services. In the event you're insurance plan determines a service to be "not covered," or over their "allowable" amount, you will be responsible for payment of the balance remaining.
- If you are unable to meet your financial obligation, you may make financial arrangements with our office or apply for charity. Please do so before your account is in arrears. If you are granted charity and neglect to adhere to your payment plan, your account will be sent to collections with the original (pre-charity) amount due.
- To avoid collection activity, payment in full is due upon receipt of the billing statement.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Please **PRINT** Patient Name: _____

_____ _____ _____

Patient Signature or legal guardian | If guardian- Relationship | Date

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Patient Privacy Practices Acknowledgement

I, the undersigned, do hereby consent and agree that I have received a copy of the Patient's Right to Privacy Policy or have declined it at this time.

_____

Print Patient Name

_____

If guardian- Relationship

_____

Patient Signature or Legal Guardian Date

Alaska Trauma & Acute Care Surgery, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATACS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-907-375-8785

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-907-375-8785.

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Email Consent

We are committed to providing you with as much information as possible to make educated decisions about your health care. We want you to have a clear understanding of your surgical procedures. By consenting to email communication, you will be allowing us to provide you with information regarding your surgical instructions, possible risks of the surgery and your post-operative expectations. Please initial by your preferred option.

_____ I consent to and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.

_____ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

_____

Email Address

_____

Print Patient Name

_____

Guardian or Responsible Party

_____ _____

Patient Signature or Legal Guardian Date

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

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HIPAA Authorization Form for Family Members/Friends

(optional)

This form is NOT a Release of Records and we are unable to send records to any physician based off this form. If you would like your records sent to a physician, please request a Records Release form from the front desk.

I, _____, give permission to all Alaska Trauma & Acute Care Surgery providers and payers to disclose and release my protected health information described below to:

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

☐ My complete health record, as above, with the exception of the following information: (check as appropriate):

- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Other (please specify_____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or Event: _____unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying your providers, preferably in writing.)

_____
Name of the Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date