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 Name: _____ **Date of Birth**: ____/____/____
First M Last

Social Security #: _____- _____ - _____ **Gender:** ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Other

Spouse/ Significant Other: _____

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

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

Primary Phone Number: _____ ☐ OK to leave detailed message ☐ Leave call back number only

Alternate Phone Number: _____ ☐ OK to leave detailed message ☐ Leave call back number only

Employer: _____ **Occupation**: _____

Referring Physician: _____ **Primary Care Physician**: _____

Preferred Pharmacy: _____ **Location:** _____

EMERGENCY CONTACT

Name: _____ **Relationship**: _____ **Phone**: _____

INSURANCE INFORMATION

Primary Insurance: _____
I.D. Number: _____ **Group:** _____
Subscriber Name (If different): _____
Subscriber Employer: _____
Subscriber D.O.B: _____
Relationship: _____

Secondary Insurance: _____
I.D. Number: _____ **Group:** _____
Subscriber Name (If different): _____
Subscriber Employer: _____
Subscriber D.O.B: _____
Relationship: _____

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

CURRENT Review of Systems

General
Fevers No__ Yes__
Chills No__ Yes__
Fatigue No__ Yes__
Change in weight No__ Yes__

Eyes
Blindness No__ Yes__
Double Vision No__ Yes__
Blurred Vison No__ Yes__
Eye Pain No__ Yes__

Ears, Nose & Throat
Deafness No__ Yes__
Tinnitus (Ears Ringing) No__ Yes__
Vertigo No__ Yes__

Cardiovascular
Chest Pain No__ Yes__
Lightheadedness No__ Yes__
Palpitations No__ Yes__

Respiratory
Shortness of breath No__ Yes__
Wheezing No__ Yes__
Do you have asthma? No__ Yes__
Chronic lung condition? No__ Yes__

Gastrointestinal
Nausea No__ Yes__
Vomiting No__ Yes__
Bowel Incontinence No__ Yes__

Genitourinary
Is urinating painful? No__ Yes__
Urinary Incontinence No__ Yes__
Sexual dysfunctions No__ Yes__

Musculoskeletal
Back Pain No__ Yes__
Joint Pain No__ Yes__
Muscle Cramps No__ Yes__

Skin
Rash/Skin Abnormality No__ Yes__
Itching of the Skin No__ Yes__

Neurologic
Numbness No__ Yes__
Weakness No__ Yes__
Dizziness No__ Yes__
Seizures No__ Yes__

Psychiatric
Anxiety No__ Yes__
Depression No__ Yes__
Hallucinations No__ Yes__

Endocrine
While eating or drinking, do you find yourself having:
Hot Intolerance No__ Yes__
Cold Intolerance No__ Yes__

Hematologic
Easily Bleed No__ Yes__
Easily Bruise No__ Yes__

Immunologic
Hives No__ Yes__
Hay Fever No__ Yes__

PAST Medical History

Cancer
Lung No__ Yes__
Breast No__ Yes__
Colon No__ Yes__
Pancreatic No__ Yes__
Brain No__ Yes__
Ovarian No__ Yes__
Prostate No__ Yes__
Growth/Tumor No__ Yes__
Chemotherapy No__ Yes__

Heart
Heart Disease No__ Yes__
Stroke No__ Yes__
High Blood Pressure No__ Yes__

ENT
ENT issues? No__ Yes__
Eye Disease No__ Yes__
Hearing Loss No__ Yes__

Skin
Skin Disease No__ Yes__
Atypical Moles No__ Yes__

Musculoskeletal
Arthritis No__ Yes__
Osteoporosis No__ Yes__
Chronic Back Pain No__ Yes__
Growth Disorder No__ Yes__

Endocrine
Endocrine Disease No__ Yes__
Diabetes No__ Yes__
If so: I__ II__
Thyroid Disease: No__ Yes__
If so: Hyper__ Hypo__
Autoimmune Disorder No__ Yes__
Kidney Disease No__ Yes__

Respiratory
Disease No__ Yes__
Asthma No__ Yes__
COPD No__ Yes__
Tuberculosis No__ Yes__

Neurological
Disease No__ Yes__
Epilepsy No__ Yes__
Headaches No__ Yes__

Psychologic
Psych Illness No__ Yes__
Depression No__ Yes__
Suicide Attempt No__ Yes__

Other:
Anemia No__ Yes__
Bleeding Disease No__ Yes__
Blood Transfusion No__ Yes__

_____

_____

_____

_____

_____

Family Medical History

SURGICAL History
If YES please include DATE

Cardiac Surgeries
Cardiovascular No__ Yes__
Valvular No__ Yes__

ENT Surgeries
Cataracts No__ Yes__
If so, L__ R__ Bilat___
Eye No__ Yes__
Sinus No__ Yes__
Septoplasty (Septum) No__ Yes__
Tonsillectomy No__ Yes__

Lung Surgeries
Lung surgery No__ Yes__

Musculoskeletal Surgeries
Orthopedic No__ Yes__
Cervical No__ Yes__
Lumbar No__ Yes__
Back No__ Yes__
Shoulder No__ Yes__
If so, What: _____
Foot No__ Yes__
Knee No__ Yes__
If so, What: _____

Genitourinary Surgeries (Males)
Prostate No__ Yes__
Vasectomy No__ Yes__

GYN Surgeries (Females)
Uterine No__ Yes__
Lumpectomy No__ Yes__
Mastectomy No__ Yes__
Breast Reduction No__ Yes__
Hysterectomy No__ Yes__
Ovary Removal No__ Yes__
Tubal Ligation No__ Yes__

Gastrointestinal Surgeries
Ulcer No__ Yes__
Appendix No__ Yes__
Colon No__ Yes__
Gallbladder No__ Yes__
Hernia No__ Yes__
Hemorrhoid No__ Yes__

Other Surgeries
_____

_____

ALLERGIES
Adhesive tape No__ Yes__
Antibiotics No__ Yes__
Betadine No__ Yes__
Etadyne No__ Yes__
Codeine No__ Yes__
Demerol No__ Yes__
Dilaudid No__ Yes__
Empirin No__ Yes__
X-ray dye/contrast No__ Yes__
Local anesthetics No__ Yes__
Other medications (list)_____

Is there any history of the following conditions amongst your FAMILY members? If so, list WHOM

Colon Cancer	No__ Yes__	Whom _____	Renal Disease	No__ Yes__	Whom _____
Lung Cancer	No__ Yes__	Whom _____	Asthma	No__ Yes__	Whom _____
Ovarian Cancer	No__ Yes__	Whom _____	COPD	No__ Yes__	Whom _____
Breast Cancer	No__ Yes__	Whom _____	Allergies	No__ Yes__	Whom _____
Skin Cancer	No__ Yes__	Whom _____	Psychiatric Issues	No__ Yes__	Whom _____
Heart Disease	No__ Yes__	Whom _____	Depression	No__ Yes__	Whom _____
Stroke	No__ Yes__	Whom _____	Substance Abuse	No__ Yes__	Whom _____
Coronary…			Osteoporosis	No__ Yes__	Whom _____
Artery Disease	No__ Yes__	Whom _____	Anemia	No__ Yes__	Whom _____
High Blood…			Thyroid Disease	No__ Yes__	Whom _____
Pressure	No__ Yes__	Whom _____	Eye Issue	No__ Yes__	Whom _____
High Cholesterol	No__ Yes__	Whom _____	Other _____		Whom _____
Diabetes	No__ Yes__	Whom _____			

Social History

Do you or have you ever used recreational drugs? No__ Yes__ If yes, what substance and for how long? _____

Have you ever smoked cigarettes? No__ Yes__ If yes, for how many years? ___ Packs per day? ____ Age/Date quit ___

Do you currently smoke cigarettes? No__ Yes__ If yes, how many packs per day? _____

Have you ever used smokeless tobacco? No__ Yes__ If yes, for how many years? ___ Frequency? ____ Age/Date quit ___

Do you currently use smokeless tobacco? No__ Yes__ If yes, how much? _____

Daily caffeine (coffee, tea, cola) consumption? No__ Yes__ How much? _____

Do you drink alcohol? No__ Yes__ How frequently? _____

Do you drink 2> alcoholic drinks per day? No__ Yes__

Have you ever had tuberculosis? No__ Yes__

Do you or have you had an STI or AIDS? No__ Yes__

Have you ever been exposed to HIV virus? No__ Yes__

Medication List

Please list ALL medications and DOSES (Including aspirin, birth control, vitamins, natural supplements & Rx)
If you have brought a copy of your medication list, please provide it to the front desk to make copies for our records.

Medication	Dose	Medication	Dose
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

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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 your 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.
- **ATACS accepts all insurance plans, including private health insurance, Medicaid, Denali Kidcare, and Tricare. We are preferred providers through Blue Cross Blue Shield. We are out of network for all other insurance plans unless an out of network deficiency has been arranged.**

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 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.