

Patient Information

Date: _____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Preferred Name: _____ Gender: _____

Marital Status: _____ SSN: _____

Mailing Address: _____ Apt or Unit #: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____

You may receive an email review request. To opt out, please speak to the front desk.

Appointment Reminders: Email Phone Call Text - **Cell Phone Carrier Required (e.g. GCI, AT&T):** _____

Employment Status: _____ Occupation: _____

Employer: _____

Emergency Contact Full Name: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____

Is there anyone you would like to give us permission to speak to regarding your medical or financial information?

If yes, please list their full name(s): _____

Insurance Information

Plan name and subscriber information is required.

Primary Insurance: _____ ID Number: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Relationship: Self Spouse Parent Other

Secondary Insurance: _____ ID Number: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Relationship: Self Spouse Parent Other

Medical Information

Reason for Visit: _____

Date of Injury or Onset: _____ Date of Surgery: _____

Cause of Injury: _____

Is this issue work related? Yes No Is this issue motor vehicle accident related? Yes No

Alcohol Use: Yes (drinks/wk: _____) No Nicotine Use: Yes No

Caffeine Use: Yes No Drug Use: Yes No

Allergies: Latex Adhesives Other: _____

Current Medications: _____

Past Medical History: _____

Major Medical History (Check All That Apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes (Type I or II) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental Health Problems |
| <input type="checkbox"/> Alzheimer's or Dementia | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> HIV | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Hepatitis (A, B, or C) | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
- Are you currently pregnant? Yes No

Patient or Guardian Agreement

- I authorize the release of information requested by my insurance plan for payment.
- I acknowledge it is my responsibility to check with my insurance carrier regarding benefit limits, authorization requirements, and services covered.
- I understand that I am ultimately responsible for any charges accrued at Alaska Hand Rehabilitation.
- I understand the terms and conditions outlined in the Alaska Hand Rehabilitation Financial and Cancellation Policies form located in my new patient folder.
- I hereby acknowledge that I have been offered a copy of Alaska Hand Rehabilitation HIPAA Omnibus located in my new patient folder. I have the right to refuse to sign this acknowledgement if I so choose.

Patient or Guarantor Signature

Date

Patient or Guarantor Name Printed

Relationship to Patient