ALASKA HAND REHABILITATION
THERAPY FOR THE SHOULDER, ARM & HAND

4015 Lake Otis Parkway Suite 200
Anchorage, AK 99508
www.akhandrehab.com
P: 907.563.8318
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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: ☐ No Reminder ☐ 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

FLIP TO OTHER SIDE →

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)

☐ Anemia	☐ Cancer	☐ Heart Attack	☐ Liver Disease
☐ Asthma	☐ Diabetes (Type I or II)	☐ High Blood Pressure	☐ Mental Health Problems
☐ Alzheimer's or Dementia	☐ Digestive Problems	☐ HIV	☐ Neurological Problems
☐ Autoimmune Disease	☐ Circulation Problems	☐ Immune Deficiency	☐ Pacemaker
☐ Breathing Difficulty	☐ Hepatitis (A, B, or C)	☐ Thyroid Disease	☐ Seizures
☐ Bleeding Disorder	☐ Heart Disease	☐ Kidney Disease	☐ Stroke

Are you currently pregnant? ☐ Yes ☐ No

Patient or Guardian Agreement

- I authorize 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 agree to comply with the terms and conditions outlined in the Alaska Hand Rehabilitation Financial and Cancellation Policies form located in my new patient folder. I understand that, should I no show more than one appointment in a 12-month period, there is a **$50.00 no show fee** for each subsequent no show event. I understand that this fee is my sole responsibility and cannot be billed to insurance of any kind.
- 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