New Patient Information

Please complete this form in its entirety. You may call 907-622-7246 if you need any help understanding or completing any part of it. Thank you.

Demographic Information

Your Name: ______________________________ Date of Birth: ____________

Any Previous Names you have gone by: ______________________________________

Social Security Number: ________________ Driver's License # / State: ________________

Preferred Phone: ___________________ Secondary Phone: ____________________

Street Address: ________________________ City/State/Zip________________

Mailing Address (if different) _____________________ City/State/Zip_____________

Email **(required for Medicare)** ____

Emergency Contact Name: _________________ Phone:__________ Relationship: ______

Gender: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Race **(required for Medicare)** ❑ American Indian or Alaskan Native ❑ Asian or Pacific Islander ❑ Black

❑ White ❑ Refuse to Report

Ethnicity**(required for Medicare)** ❑ Hispanic ❑ Non-Hispanic ❑ Refuse to Report

Primary Language: ❑ English ❑ Korean ❑ Russian ❑ Spanish ❑ Tagalog ❑ Other _______________

Disabilities requiring special assistance: ______________________________________

Primary Insurance Plan

Payer (e.g. BC/BS): ____________________ Plan: _______________

Policy/I.D. Number: ____________________ Group Number: ______________

Complete this box if you are *not* the policy holder for your primary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: _____________________

Policy Holder Name: ____________________ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: ____________________ Social Security Number: ____________

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): ____________________ Plan: ____________________

Policy/I.D. Number: ____________________ Group Number: ______________

Complete this box if you are *not* the policy holder for your secondary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: _____________________

Policy Holder Name: ____________________ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: ____________________ Social Security Number: ____________

NAME ____ HEIGHT ________ WEIGHT _________

Allergies

Please list all medication allergies below, or check "None" if none known. ❑None

Medication	Reaction	Medication	Reaction

Topical Allergies: ❑Iodine ❑Latex ❑Tape

Are you allergic to shellfish? ❑Yes ❑No

Current Medications

Please list *all* medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Medical History *(Check all that apply)*

□ (FEMALES ONLY) Date of last menstrual period? ____________ # of pregnancies/births: ___ / ___

□ AIDS/HIV □ Alcoholism □ Anemia □ Anxiety □ Asthma

□ Atrial fibrillation □ Bipolar mood disorder □ Cancer ____

□ Chronic kidney disease □ Cirrhosis □ Congestive heart failure □ COPD

□ Coronary disease □ Depression □ Diabetes □Epilepsy / seizures

□ Fibromyalgia □ Gastric ulcer □ Heart attack □ Hepatitis A / B / C *(circle all that apply)*

□ High blood pressure □ High cholesterol □ Lupus □ Menstrual problems

□ Migraines □ Multiple sclerosis □ Pacemaker/defibrillator □ Rheumatoid arthritis

□ Schizophrenia □ Sexually transmitted infections ____

□ Sleep apnea □ Thyroid problems: high / low □ Tuberculosis

□ Other ____

NAME ____

Accident/Trauma History *(Since age 18; check all that apply.)*

□ Fructures / dislocations □ Head injury □ Injury from auto accident □ Blood transfusion

□ Injury from assault or combat □ Alcohol or drug-related injury

Surgical History *(Please write down any operations you have had, and the year if you remember)*

____

____

Social / Spiritual History

Occupation _________________________ Currently working? Y / N # Days worked last month _____

Highest level of education ____________________ Technical / Trade training _____________________

Means of transportation? ____________________ Own or rent home/apartment? _________________

Living with ____

Are you capable of becoming pregnant ? YES / NO Sexually active ? ____________________________

Do you consider yourself spiritual or religious ? YES / NO ______________________________________

Family History *(BIOLOGICAL PARENTS ONLY – if you are adopted / do not know your biological parents please skip this section; if your biological parents are deceased please check "deceased"). Otherwise, please check all that apply.*

Mother: □ Deceased □ Alcoholism □ Other substance abuse ______________________

□ Anxiety □ Cancer ______________________ □ COPD □ Depression

□ Diabetes □ Heart problems □ High blood pressure □ Kidney problems

□ Thyroid problems □ Other ____

Father: □ Deceased □ Alcoholism □ Other substance abuse ______________________

□ Anxiety □ Cancer ______________________ □ COPD □ Depression

□ Diabetes □ Heart problems □ High blood pressure □ Kidney problems

□ Thyroid problems □ Other ____

NAME ____

Siblings: □ Alcoholism □ Other substance abuse ___________________________________

Review of Systems *(Circle any you have experienced in the past 2 weeks)*

Constitutional

Fatigue

Fever / Chills

Night Sweats

Weight Loss / Gain

Insomnia

Eyes

Recent Visual Changes

Head/ENT

Headache

Sinus problems

Hearing Problems

Ringing in the Ears

Recurrent Sore Throats

Dizziness (Vertigo)

Dental Problems

Respiratory

Shortness of breath

Cough

Coughing up blood

Wheezing

Cardiovascular

Chest Pain

Palpitations

Shortness of Breath

Nighttime Shortness of Breath

Can't Sleep Laying Flat

Fainting/Lightheadedness

Feet or Leg Swelling

Gastrointestinal

Loss of appetite

Difficulty swallowing

Heartburn

Nausea / Vomiting

Vomiting Blood

Bloody or Dark, Tarry Stools

Abdominal Pain / Cramps

Diarrhea

Constipation

Genitourinary

Blood in Urine

Change in Urine Flow/Frequency

Flank Pain

Painful Urination

Urinary incontinence

Endocrine

Excessive thirst

Cold tolerance decrease

Heat tolerance decrease

Excessive sweating

Weakness of muscles

Hematologic

Easy bleeding

Easy bruising

Musculoskeletal

Neck Pain / Back Pain

Muscle Aches / Spasms

Joint Pain

Joint Swelling / Stiffness

Neurological

Dizziness / Fainting

Confusion / Memory Loss

Speech disturbance

Limb weakness / Paralysis

Involuntary movements

Instability When Walking

Numbness / Tingling

Seizures

Tremors

Psychiatric

Feeling Anxious

Depressed Mood

Suicidal Thoughts

Suicidal Planning

Skin

New skin discoloration

New rash

Open sores

NAME ____

Mental Health History

Have you ever been hospitalized for mental health concerns or problems? Y / N

Have you ever hurt yourself on purpose? Y / N *Have you ever tried to kill yourself?* Y / N

Have you ever been treated by a mental health provider? Y / N

Are you currently being treated by a mental health provider? Y / N

Over the past 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed or hopeless	0	1	2	3
3.	Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking much more slowly than usual; Or the opposite – fidgety or restless	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Over the past 2 weeks, how often have you been bothered by any of the following problems?		Not At All	Several Days	More Than Half the days	Nearly Every Day
1.	Feeling nervous, anxious, or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3
3.	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it is hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid, as if something awful might happen	0	1	2	3

NAME ____

Substance Abuse History

Is your treatment at the directive of a court system or the correctional system? Y / N

Are you currently on parole? Y / N Name / phone # of parole officer: ________________________

What is/are your drug(s) of choice? ____

For what are you seeking treatment through Set Free? ____

Have you ever been incarcerated for substance-related issues? Y / N

Have you had other legal troubles because of substance-related issues? Y / N

I consider my initial or "gateway" substance to be ____

Please write in any and all substances that apply to the questions below:

I've used more of ____ than I want to.

(I've used them longer than I want to, also) Y / N

I've been unable to cut back on my use of ____

I spend too much time trying to get, use or recover from using _________________________________

I crave (substance) ____

My use of ___________________________________ causes relationship and interpersonal problems.

My use of ___________________________________ has compromised / negatively affected work, social or recreational activities

I use / have used ___________________________________ in risky/dangerous ways or situations.

I keep using ___________________________________ even though I know it's harming my body and mind.

I've become tolerant to (need more of) ____

I've experienced withdrawal from ____

Have you ever been hospitalized or gone to the Emergency Room for complications from drugs? Y / N

Have you ever overdosed? Y / N On what? ____

NAME ____

Have you had any known health problems from substances (like liver disease, seizures, infections, heart problems)? ____

Please fill out the following:

	Alcohol	Opioids (including heroin, fentanyl)	Methamphetamines	Marijuana	Other (fill in) ___________
Age I first used					
How I got started					
When it became a problem					
Amount I use daily (average)					
Most I ever used in a day					
$ amount I spend on, weekly					
Last time I used					
Longest time period I was clean					
Inpatient/residential treatment / Where?					
[I completed inpatient/residential]					
Outpatient treatment / Where?					
[I completed outpatient/residential]					
How many treatment episodes total have you done for:					
Have you ever been treated with medicine for substance abuse?					

I am currently :

NAME ____

Medical History and Consent for Treatment, Including TeleHealth Consent

Initial next to each paragraph to indicate that you have read, understood and agree with its content.

___ I authorize Northern Anesthesia & Pain Medicine (NAPM) and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

___I acknowledge that I have had the opportunity to review NAPM's Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

___I acknowledge that I have had the opportunity to review NAPM's Price Transparency Fee Schedule, which is displayed for public inspection at its facility and on its website.

___I give my consent for NAPM to retrieve and review my medical and behavioral health history. I understand that this will become part of my medical record.

___I authorize NAPM to release my Protected Health Information (medical records) to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize NAPM to release any information required in obtaining procedure authorization or the processing of any insurance claims.

___I understand that NAPM will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

___ *If, during or after the COVID19 National Public Health Emergency my NAPM Provider advises the use of telehealth services, I consent/agree to receive telehealth services including assessment, treatment, diagnosis, and education, using interactive audio, video, and data communications. During my visit, my NAPM Provider and I will be able to see and speak with each other from remote locations. I consent to forwarding my information to a third party as needed to receive telehealth services, and I understand that existing confidentiality protections apply. I acknowledge that while telehealth can be used to provide improved access to medical care, as with any medical procedure, there are potential risks and no results can be guaranteed or assured.*

I understand and agree that potential risks of telehealth include: (i) limited or no availability of diagnostic laboratory, x-ray, EKG, and other testing, and some prescriptions, to assist my medical provider in diagnosis and treatment; (ii) my provider's inability to conduct a hands-on physical examination of me and my condition; and (iii) delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures. I will not hold NAPM responsible for lost information due to technological failures.

I further understand that my NAPM Provider's advice, recommendations, and/or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. I understand that my NAPM Provider relies on information provided by me before and during our telehealth encounter and that I must provide information about my medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my ability.

NAME ____

___*I may discuss these risks and benefits with my NAPM Provider and will be given an opportunity to ask questions about telehealth services. I have the right to withdraw this consent to telehealth services or end the telehealth session at any time without affecting my right to future treatment by NAPM.*
I understand that reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation. All existing confidentiality protections under federal and Alaska State law apply to information disclosed during this telehealth consultation.
I understand that telehealth visits are currently covered by all major forms of health insurance however as with all medical services I am ultimately responsible for payment of services rendered by NAPM.

___I understand that NAPM, as a Christian faith-based organization may offer prayer to me, which I have the right to refuse. I understand that NAPM may request offsite prayer on my behalf for my physical, mental/emotional and spiritual health condition, disclosing only my first name, and I have the right to forbid this by signing here: ____

___ I certify that the information herein is accurate, complete and true.

By my signature below, I certify that I have read, understood and agree with all provisions of NAPM's consent for treatment.

Signed:____ Date: _______________________