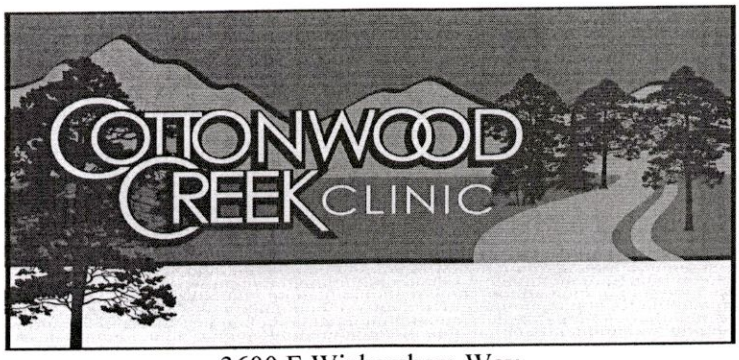

3600 E Wickersham Way
Wasilla, AK 99654
Phone: (907) 373-5950
FAX: (907) 373-5954

PATIENT REGISTRATION

Thank you for choosing our office. Please print legibly

To serve you properly we will need the following information

Patient's Full Legal Name: _____

Date of Birth: _____ Gender: Male or Female Marital Status: M S D W

Social Security Number: _____

Mailing Address: _____

_____

Physical Address: _____

_____

Home Phone #: _____ Cell Phone #: _____

Employer: _____Work Phone #: _____

May we call you at work? Yes or No Are You a Veteran? Yes or No

Emergency Contact Person and Phone #: _____

Relationship to Patient: _____

PRIMARY INSURANCE (THIS INCLUDES MEDICARE AND MEDICAID)
We do not provide MEDICAID travel vouchers

Insurance Company Name: _____
Policy #: _____ Group #: _____
Primary Policy Holders Name: _____
Primary Policy Holders Date of Birth: _____
Primary Policy Holders Social Security #: _____
Primary Policy Holders Address: _____
Primary Policy Holders Phone #: _____
Employer Insurance Plan? Yes or No
Insurance Company Address:
_____
_____
Insurance Company Phone #: _____

SECONDARY AND/OR MEDICARE SUPPLEMENTAL INSURANCE

Insurance Company Name: _____
Policy #: _____ Group #: _____
Secondary Policy Holders Name: _____
Secondary Policy Holders Date of Birth: _____
Secondary Policy Holders Social Security #: _____
Secondary Policy Holders Address: _____
Secondary Policy Holders Phone #: _____
Employer Insurance Plan? Yes or No
Insurance Company Address:
_____
_____
Insurance Company Phone #: _____

TERTIARY INSURANCE

Insurance Company Name: _____
Policy #: _____ Group #: _____
Tertiary Policy Holders Name: _____
Tertiary Policy Holders Date of Birth: _____
Tertiary Policy Holders Social Security #: _____
Tertiary Policy Holders Address: _____
Tertiary Policy Holders Phone #: _____
Employer Insurance Plan? Yes or No
Insurance Company Address:
_____
_____
Insurance Company Phone #: _____

Health History (Confidential)
Today's Date: ____/____/_____

Name: _____
First MI Last
Date of Birth:_____/_____/_____
Date of Last Physical: _____
Most recent PCP location/name: _____
Reason for Establishing Care: _____
WE DO NOT PROVIDE PAIN MANAGEMENT
Symptoms Check List (Symptoms you currently have or have had in the past year)

General

__ Chills
__ Depression
__ Dizziness
__ Fainting
__ Fever
__ Forgetfulness
__ Headache
__ Loss of sleep
__ Nervousness
__ Sweats

Gastrointestinal

__Appetite poor
__Bloating
__Bowel Changes
__Constipation
__Excessive hunger
__Excessive Thirst
__Gas
__Hemorrhoids
__Indigestion
__Nausea
__Rectal Bleeding
__ Stomach Pain
__ Vomiting
__ Vomiting blood

Eye, Ear, Nose, Throat

__Bleeding gums
__Blurred Vision
__Crossed eyes
__Difficulty swallowing
__Double vision
__Earache
__Ear discharge
__Hay fever
__Hoarseness
__Loss of hearing
__Nosebleeds
__ Persistent cough
__ Pain/Ringing in Ears
__ Sinus problems
__Vision flashes
__ Vision halos

Muscle/Joint/Bone
weakness, numbness in:

__Arms __Hips
__Back __Legs

__Feet __Neck
__Hands __Shoulders

Cardiovascular

__ Chest pain
__ High Blood Pressure
__ Irregular heart beat
__ Poor circulation
__ Rapid heat beat
__ Swelling of ankles
__Varicose veins

Skin

__ Bruise easily
__ Hives
__ Itching
__ Change in mole
__ Rash
__ Scars
__ Non healing sore

Genito – Urinary

__ Blood in urine
__Frequent urination
__Lack of bladder control
__Painful urination

Females Only

__ Abnormal PAP
__ Bleeding between periods
__ Breast lump
__ Hot flashes
__ Nipple discharge
__ Vaginal discharge
__ Extremely painful menstruation

Men only

__ Breast lump
__ Erectile difficulties
__ Testicular lump
__ Penial discharge
__ Sor on penis
Other _____

Conditions: (Check any conditions you have or have had in the past)

AIDs		*Chemical Dependence*		*Herpes*		*Polio*	
Alcoholism		*Chicken pox*		*High cholesterol*		*Psychiatric care*	
Anemia		*Diabetes*		*HIV positive*		*Rheumatic fever*	
Anorexia		*Emphysema*		*Kidney disease*		*Scarlet fever*	
Appendicitis		*Epilepsy*		*Liver disease*		*Stroke*	
Arthritis		*Glaucoma*		*Measles*		*Suicidal attempt*	
Asthma		*Goiter*		*Migraines*		*Thyroid problems*	
Bleeding disorders		*Gonorrhea*		*Mononucleosis*		*Tonsilitis*	
Bronchitis		*Gout*		*Multiple sclerosis*		*Tuberculosis*	
Bulimia		*Heart disease*		*Mumps*		*Typhoid fever*	
Cancer (type)		*Hepatitis*		*Pacemaker*		*Ulcers*	
Cataracts		*Hernia*		Pneumonia		*Venereal disease*	

*Allergies:

Medication allergy	*Reaction*
*	
*	
*	
*	

* **Please include all medications as well as any vitamins and supplements.** (*Bring in all medication bottles to initial appt)*

Preferred pharmacy: _____

Medication name	*Strength*	*How often everyday*

*If medications exceed space above, please provide a complete list on a separate sheet. (Please bring all medications to initial appointment)

Family History: Please check if your blood relatives have had any of the following:

Conditions	**Father**	**Mother**	**Sibling 1**	**Sibling 2**	**Sibling 3**	**Sibling 4**	**Father Parents**	**Mothers Parents**
			M/F	M/F	M/F	M/F		
Alive								
Deceased								
Alcoholism								
Arthritis								
Asthma								
Bleeding disorders								
Blood clots								
Brain Aneurysm								
Cancer (Which type?)								
Diabetes (1 or 2)								
Heart Disease								
High Blood Pressure (HTN)								
Thyroid Disease								

Vaccinations:

Type	*Yes or No*	*When*
Flu	Y/N	
COVID-19	Y/N	
Pneumonia	Y/N	
Shingles	Y/N	

Preventative Tests:

Test	*Yes or No- Normal or abnormal*	*Date 00/0000*
Colonoscopy		
Mammogram		
Dexascan		
Prostate/PSA		

Women Only:

	When and was it normal or abnormal
Last menstrual cycle	
Last PAP	
Currently pregnant	

Injury/Illness:

Serious injury/illness	***Date 00/0000***	***Hospitalized?*** *Yes/No*

Social History:

Substances	Y or N		Frequency/duration	***Other***	Frequency/duration
Tobacco use		*Packs/cans/day*		*Exercise*	
Recreational drugs		*Type/frequency*		*Caffeine*	
Alcohol use		*Drinks/week*		*Sleeping*	

Surgical History:

Surgery type & location	***Date 00/0000***

PLEASE READ AND (INITIAL) AT THE END OF EACH PARAGRAPH

Financial Responsibility

- If you are a cash pay patient, payment is due at the time of service. If there is a problem, please speak to the staff prior to seeing the provider. (_____)
- This office does provide insurance billing as a courtesy to our patients that have insurance. Payment of the insurance co-pay and /or deductible is due at the time of service. (_____)
- I give this office permission to bill my insurance company on my behalf. (_____)
- All fees are the responsibility of the patient. We will not be involved in disputes with insurance companies. (_____)
- If this account becomes delinquent and is assigned to a collection agency**, an administration fee of 25.00** will be added to the delinquent balance and charged to the patient. (_____)
- At this point we will no longer provide medical care for you and you will need to find a new medical provider. (_____)
- There will be a **$40 NO SHOW FEE** for appointments that are not canceled 24 HOURS in advance, this fee is not covered by your health insurance policy. This fee will have to be paid in full to schedule another appointment. (_____)
- I hereby authorize payment of benefits due to me, directly to the provider, for his/her service as described. I understand that I am financially responsible for this account and charges, not covered by my insurance. I also authorize the release of information relating to this claim or any other claim for services rendered by the provider now or in the future. (_____)

In signing this, I acknowledge an understanding of the above policy and my agreement with them.

_____ _____

Print Name DOB

_____ _____

Signature of patient or Legal Guardian Date

Cottonwood Creek Clinic

3600 E Wickersham Way

Wasilla, AK 99654

We would like to offer you access to our Patient Portal.

In order to send you a Patient Portal Invitation, we will need your email address (Please Print Clearly): _____

Look for an email from "Health Alert" or "YourHealthFile" in your Junk/Spam Folder, if it is not in your Inbox.

☐ Accept

☐ Decline

Our Electronic Medical Records System is able to remind you of your upcoming appointment by text and/or email. In the event we do not have the staffing available to call you, this will ensure that you do receive a reminder prior to your appointment.

Do not rely on a phone call to remind you of your appointment.

Cell Phone # : _____

Email (Please Print Clearly): _____

Patient Signature: _____ Date: _____

Printed Name: _____

Cottonwood Creek Clinic LLC
3600 E Wickersham Way
Wasilla, AK 99654
Phone 907-373-5950
Fax 907-373-5954

HIPAA Acknowledgement and Consent Form

The Privacy Act was created in order to provide a standard for health care providers to obtain their patient's consent for uses and disclosure of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take responsible precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment. Payment or health care operations, in order to provide services that are in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect relationships with you (i.e. laboratories that only interact with physicians) and may have to disclose personal health information for the purpose of treatment, payment, or health care operations. Their entities are not required to obtain patient consent.

I understand that my health information may include information both created and received by the practice, may be in the form of writing, electronic records, spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I understand and agree that this practice may use and disclose my health information in order to:

Make decisions about and plan for my care and treatment.

Refer to, consult with coordinate among, and manage along with other health care providers for my care and treatment.

Determine my eligibility for health plans or insurance coverage, and submit bills, claims and other related information to insurance companies or a responsible agent for payment of my health care.

Perform various office, administrative, and business functions that support my physician's effort to provide me with, arrange and be reimbursed for quality health care.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing as mandated by the Privacy Act. Under this law, we have the right to refuse treatment should you choose not to disclose your information. I also understand that I have the right to ask that some or all my health care information not be used or disclosed and understand that this practice is not required by law to agree with such request.

People Authorized to get medical / billing information.

Name: _____ Phone _____ Relationship: _____

Name: _____Phone _____
Relationship: _____

Name: _____ Phone _____ Relationship: _____

Name: _____ Phone _____ Relationship: _____

Name: _____ Phone _____ Relationship: _____

Name: _____ Phone _____ Relationship: _____

Name: _____ Phone _____ Relationship: _____

I have reviewed and understand this consent form:

Patient Signature: _____ DOB_____
Printed Name: _____DATE_____

Revised 6/2/22