Alaskan Interior Urology

Medical Dental Arts Bldg.
1919 Lathrop St. Suite 207
Fairbanks, AK 99701

ADULT REGISTRATION FORM

Do you wish your family financial record to be listed in the patient or spouse name? Please check one: ❑Patient ❑Spouse

Race: Ethnicity: Preferred Spoken Language:

PLEASE PRINT

PATIENT INFORMATION

Patients Name | Date of Birth | Sex | Social Security No.

Mailing Address | City | State | Zip | Home Phone

Employer (If self, name of business) | Dept./Position Held | Union/Local No. | Work Phone/Ext

In case of emergency notify: | Address | Relationship | Phone

SPOUSE INFORMATION

Spouse Name | Date of Birth | Sex | Social Security No.

Mailing Address | City | State | Zip | Home Phone

Employer (If self, name of business) | Dept./Position Held | Union/Local No. | Work Phone/Ext.

COMPLETE FOR EACH COMPANY (please bring your insurance card to the appointment)

Insurance Company	Primary Insurance	Secondary Insurance	Tertiary Insurance	Other Insurance
Policy Holder's Name				
Policy Holder's Date of Birth				
Relation to Policy Holder				
Identification No. Policy or Group No.				
Insurance Address				

AUTHORIZATION: I understand full payment received is my responsibility regardless of my insurance coverage.
I hereby authorize the Clinic to release my insurance information acquired in the course of examination or treatment.
I further authorize my insurance company to pay directly to the Clinic any medical/surgical benefits due to me that have not been paid in full. This authorization shall expire upon written notice or one year from this date.

SIGNATURE Date

We ask that all patients arrive at their "Check In" time, there is a 15 minute "Grace Period" after that time has expired you will be considered a "No Show" and will be susceptible to the "No Show Fee" of $30. If you are running late please call at let us know so we may adjust accordingly

HIPAA CONSENT FORM

I give Alaskan Interior Urology, LLC my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review Alaskan Interior Urology, LLC's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Alaskan Interior Urology, LLC is not required to agree to the request. If Alaskan Interior Urology, LLC agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

May we leave a detailed message at the phone numbers you have listed? Yes ☐ No ☐

Signature: _____ Date: _____

Patient, parent or guardian

Please list any family member(s) that you would like to allow us to discuss your medical treatment and care with:

_____

If signed by patient representative, state relationship to patient: _____

ALASKAN INTERIOR UROLOGY
1919 Lathrop St, Suite 207
FAIRBANKS, AK 99701
907-458-0700

A clear understanding of your financial responsibility for care is essential in assuring a professional relationship with our staff. Please read this form carefully and have your questions answered before signing.

Payment: We accept cash, checks or visa and master card.

Insurance: Remember-You are ultimately responsible for your bill. If you have private insurance, as a courtesy, we will bill your Insurance for our services once per visit or procedure. All patients are asked to pay the full amount for services at the beginning of each year until deductible is met. You will then be expected to pay your "co-pay" at each following visit. Any overpayments will be refunded to the appropriate party. If there is a balance left after your insurance has paid, you will be billed; that amount is due upon receipt of your first statement from our office. If your Insurance has not paid for any reason, you will be billed and are responsible for the charges on receipt of your first statement from our office. Please remember that insurance is a contract between you and your insurer. We will be happy to help if we can but will not become involved in disputes concerning deductible, co-payments, secondary insurance or so-called "usual and customary" reductions by your insurer.

Medicare Patients: Please remember that you have a yearly deductible and copay for each visit. Medicaid Patients: Please be prepared to pay your $3.00 co-pay at time of service.

Veteran's Administration Patients: You are required to get PRE-AUTHORIZATION before each visit if you want VA to pay. A 5 day notice is now required by VA; it is your responsibility to see this is done. VA authorization must be received in our office before each visit. If no authorization is received, you will be expected to pay in full at the time of service.

Chief Andrew Isaac Health Center Patients: You must bring a purchase order from Contract Health for each and every visit. This is their requirement for us to be paid. If no purchase order is provided, you will be expected to pay at the time of service unless you have Medicaid coupons.

Workers Compensation: No retroactive filing will be done by our office. If it is work related, you must state that at the time of service and be prepared will all necessary information.

If you fail to cancel and do not show for any appointment, you will be charged a $30 fee. This fee will be billed directly to you and not your insurance. After 3 no shows, no further appointments will be made for you. Mail Returns (no forwarding address): Upon return to our office, these accounts will be sent immediately to our Collection Agency.

Delinquent Accounts: Past due accounts may be referred to our Collection Agency for collections. You will be responsible for all collection fees incurred in addition to the past due balance. There will be a 50% handling fee added if your account is sent to collections. Once an account has been placed with the Collection Agency, all questions must be directed to their office. Additionally we will not be liable for any consequences which may result from a collection agency's effort to obtain payment.

Printed Name Signature Date

ALASKAN INTERIOR
UROLOGY ASSIGNMENT
OF BENEFITS

I authorize and request that payment be made to Alaskan Interior Urology for services rendered. I agree that this authorization will cover *all* medical services rendered until such authorization is revoked by me. A copy of this form may be used in lien of original document.

Your insurance company may request chart notes in order to process your claim. By signing below, you are authorizing us to release pertinent clinical information to your insurance company.

_____

Patient Signature

_____

Parent Signature (if patient is minor child)

_____

Date

Urology Patient Questionnaire

Name:_____**DOB**:_____**Date**:_____

Reason for appointment:

_____

_____

→For the next four fields, you may WRITE YOUR RESPONSES or CHECK THE BOXES on pages 2-4←

Today's Symptoms- Please list/describe your symptoms. See page 3 for a list of common problems.

_____

_____

Referring Physician/Clinic:_____

Medications- Please list all current medications. See page 2 for a list of common drugs.

- _____Dose/Strength:_____
- _____Dose/Strength:_____
- _____Dose/Strength:_____

Do you have any allergies? **Y/N** If yes, list:_____

Do you have a pain contract with another doctor? **Y/N** If yes, please list where:_____

Past Medical History- Please list all known conditions, past and present. See page 3 if you need assistance.

- _____
- _____
- _____
- _____
- _____
- _____

Past Surgical History- Please list all surgeries. See page 4 for a list of common procedures.

- _____ _____Month/Year:_____ _____

Social History

Married/Single/Other If other, specify: _____ **Do you have children?** **Y/N** If so, how many? _____

Occupation:_____ **Alcohol:** **Y/N** If yes, please specify:_____ drinks per_____

Tobacco: **Y/N** If yes, list type and how much: _____ **Recreational Drugs**: **Y/N** If yes, list: _____

Name:_____**DOB:**_____**Date**_____

Common Medications (Please check all that apply)

- ☐ Advair Diskus
- ☐ Albuterol
- ☐ Allergy Medication:_____
- ☐ Ambien
- ☐ Antibiotics:_____
- ☐ Antidepressant:_____
- ☐ Ativan (Lorazapam)
- ☐ Celebrex
- ☐ Coumadin (Warfarin Sodium)
- ☐ Effexor
- ☐ Furosemide
- ☐ Gabapentin (Neurontin)
- ☐ Hydrochlorothiazide
- ☐ Ibuprofen
- ☐ Klonopin (Clonazepam)
- ☐ Levothyroxine
- ☐ Lipitor
- ☐ Lisinopril
- ☐ Metformin (Glucophage)
- ☐ Metoprolol
- ☐ Naproxen
- ☐ Nexium (Esomeprazole)
- ☐ Norvasc
- ☐ Pantoprazole
- ☐ Plavix
- ☐ Potassium Chloride
- ☐ Prednisone
- ☐ Premarin
- ☐ Prevacid
- ☐ Prilosec (Omeprazole)
- ☐ Prozac
- ☐ Simvastatin (Zocor)
- ☐ Singulair
- ☐ Synthroid (Levothyroxine)
- ☐ Tylenol
- ☐ Xanax
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

Name:_____ **DOB:**_____ **Date**_____

Today's Symptoms (check boxes for any that apply)

Genitourinary/Urologic

- ☐ Blood in Urine
- ☐ Dribbling or Weak Stream (Circle One)
- ☐ Burning with Urination
- ☐ Erection/Ejaculation Problem (Circle One)
- ☐ Kidney/Bladder Stone(s) (Circle One)
- ☐ Bladder/Kidney Infection (Circle One)
- ☐ Sensation of Not Emptying
- ☐ Bladder Pain
- ☐ Testicular/Scrotal Swelling
- ☐ Urgency/Frequency/Hesitancy (Circle One)
- ☐ Urinary Incontinence
- ☐ Urinary Tract Infection
- ☐ Inability to Urinate
- ☐ Prostatitis
- ☐ Bedwetting
- ☐ Vaginal Bleeding/Discharge (Circle One)
- ☐ Flank/Kidney Pain
- ☐ Other_____

Constitutional

- ☐ Appetite Change
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Weight Loss
- ☐ Other_____

Eyes

- ☐ Blindness
- ☐ Blurred Vision
- ☐ Other_____

Neurological

- ☐ Dizzy Spells
- ☐ Headache
- ☐ Leg or Arm Weakness (Circle One)
- ☐ Memory Loss
- ☐ Numbness/Tingling
- ☐ Other_____

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Acid Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Indigestion/Heartburn
- ☐ Nausea/Vomiting
- ☐ Rectal Bleeding/Bloody Stools
- ☐ Tarry Stool
- ☐ Other_____

Cardiovascular

- ☐ Chest Pain/Angina
- ☐ Irregular Heartbeat/Palpitations (Circle One)

Skin

- ☐ Rash
- ☐ Other_____

Musculoskeletal

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Cramps/Spasms
- ☐ Other_____

Ears/Nose/Throat

- ☐ Ear Infection
- ☐ Sinus Congestion
- ☐ Other_____

Respiratory

- ☐ Asthma
- ☐ Emphysema/Bronchitis (Circle One)
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Other_____

Psychological

- ☐ Anxious/Depressed (Circle One)
- ☐ Other_____

Name:_____**DOB:**_____**Date**_____

Health History (Check boxes for any conditions that apply, past or present)

- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Aortic Aneurysm
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Chronic Fatigue
- ☐ Colitis
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
  - ☐ Type 1
  - ☐ Type 2
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Herniated Disc
- ☐ Hiatal Hernia
- ☐ Hypertension
- ☐ Irritable Bowel Disease
- ☐ Kidney Disease
- ☐ Kidney Infection
- ☐ Migraine
- ☐ Mitral Stenosis
- ☐ Mitral Insufficiency
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Peptic Ulcer
- ☐ Phlebitis
- ☐ Prostatitis
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Heart Attack

Date:_____

- ☐ Stroke

Date:_____

- ☐ Transplant Recipient

Site:_____

- ☐ Cancer

Type:_____

- ☐ Other:_____
- ☐ Other:_____

Surgical History (Please check all that apply, and provide Month/Year)

- ☐ Appendectomy
  - Date: _____
- ☐ Cataract Surgery
  - Date: _____
- ☐ Cesarean Section
  - Date: _____
- ☐ Gallbladder Removal
  - Date: _____
- ☐ Hemorrhoidectomy
  - Date:_____
- ☐ Hysterectomy
  - Date: _____
- ☐ Mastectomy
  - Date: _____
- ☐ Prostatectomy
  - Date: _____
- ☐ Tonsillectomy
  - Date _____
- ☐ HerniaRepair,Type: _____
  - Date: _____
- ☐ Oral Surgery, Type: _____
  - Date: _____
- ☐ BackSurgery, Type:_____
  - Date: _____
- ☐ CardiovascularSurgery, Type: _____
  - Date: _____
- ☐ Urologic Surgery, Type: _____
  - Date: _____
- ☐ Other:_____
  - Date: _____
- ☐ Other:_____
  - Date: _____