PATIENT REGISTRATION

First Name:_____ MI: _____ Last Name:_____

Preferred Name:_____ Date of Birth:_____

Mailing Address: _____

City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____Work Phone:_____

Marital Status: (Circle One) M S W D Sex: Male ( ) Female ( ) Social Security #_____

REFERRING PHYSICIAN:_____

PRIMARY CARE PHYSICIAN :_____

Language Spoken:_____ Race:_____ Ethnicity:_____

Name of Responsible Party if other than patient:

First Name:_____ Last Name:_____ MI:_____

SSN:_____ Relationship to Patient _____DOB:_____

INSURANCE:

Primary Insurance Carrier: _____ Policy Number: _____

Subscriber:_____ Date of Birth: _____

Secondary Insurance Carrier: _____ Policy Number: _____

Subscriber:_____ Date of Birth: _____

BENEFIT ASSIGNMENT / ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I certify that the above information is true and correct to the best of my knowledge. The doctor has my permission to administer and perform any procedure deemed necessary for diagnosis and treatment and to obtain medical records from outside sources that may be important for the continuation of my care (or the best interests of my dependent if I am signing as a parent or guardian).

I authorize payment of medical benefits to Mat Su Surgical Associates. I understand that I am financially responsible for all charges, whether or not paid by insurance. **I** authorize the release of any information necessary to secure the payment of benefits. I agree that all charges for medical services rendered that are not directly paid by my insurance will be my responsibility. **I** also understand that Mat Su Surgical Associates can utilize an outside collection agency for all unpaid bills.

I hereby acknowledge that **I** have been presented with a copy of Mat Su Surgical Associates' NOTICE OF PRIVACY PRACTICES.

_____ _____

Patient / Responsible Party Date

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

I hereby consent to the use or disclosure of my Protected Health Information by Mat Su Surgical Associates, in order to render treatment, payment and/or coordination of care with other providers.

I do understand that I retain the right to revoke this consent. Such revocation must be submitted to Mat Su Surgical Associates in writing. The revocation shall be effective except in those instances that occurred prior to the revocation.

I have read and understand this information. I am the patient or the individual authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

_____ _____

Patient Name (Please Print) **Signature and Date**
(if you are signing for the patient, list your relationship to the patient)

Consent to Disclose Health Information to Family Member and/or Friends

I give permission for my Protected Health Information to be disclosed to the family members and/or others listed below for the purpose of communicating results, findings, care decisions and appointment information:

Name: _____Relationship:_____ Phone Number: _____

Name: _____Relationship:_____ Phone Number: _____

Please list the family members or others, if any, whom we may inform about your medical condition **<u>ONLY IN AN EMERGENCY</u>**:

Name: _____Relationship:_____ Phone Number: _____

Name: _____Relationship:_____ Phone Number: _____

Consent for Appointment reminders and other Healthcare Communications

We use an automated system for appointment reminders: Phone Call, Text and Email.

Can we send you a text reminder? YES NO If yes, what number: _____

Our office does not charge for this service, but standard text messaging rates may apply (contact your carrier for plans and details)

Can we email you about your appointments? YES NO If yes, what email: _____

Can we leave confidential messages on your answering machine or voicemail: YES NO

Garth LeCheminant, M.D. David Morrow, M.D. Jennifer Lemert, N.P.
Kayla Mitchell, R.N., W.O.C.N.
2490 S. Woodworth Loop, Ste 450 Palmer, AK 99645
Phone: (907) 745-8100 Fax: (907) 746-2655

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Notes:_____

Sex

- ⬭ Male
- ⬭ Female
- ⬭ Other
- ⬭ Unknown

Email

Please check one as your preferred email for communications

- ⬭ Personal:_____
- ⬭ Work:_____

Race

Select one or more

- ⬭ White
- ⬭ Black or African American
- ⬭ Asian
- ⬭ American Indian or Alaska Native
- ⬭ Native Hawaiian or Other Pacific Islander
- ⬭ Other Race
- ⬭ Unknown
- ⬭ Patient declines to specify
- ⬭ Prohibited by state law

Ethnicity

- ⬭ Hispanic or Latino
- ⬭ Not Hispanic or Latino
- ⬭ Patient declines to specify
- ⬭ Prohibited by state law
- ⬭ Unknown

Preferred Language

- ⬭ English
- ⬭ Russian
- ⬭ Spanish; Castilian
- ⬭ Patient declines to specify

Contact Preference

- ⬭ Letter
- ⬭ Email
- ⬭ Patient declines to specify
- Other:_____

Pharmacy

Name	Address	Phone

Past or Present Medical Conditions

- [ ] None

- [ ] Anemia
- [ ] Anxiety disorder
- [ ] Arthritis
- [ ] Asthma
- [ ] Atrial fibrillation
- [ ] Barrett's Esophagus
- [ ] Bipolar disorder
- [ ] Blood Clots (Leg)
- [ ] Blood Clots (Lung)
- [ ] Bowelobstruction
- [ ] Celiac disease
- [ ] Colon cancer
- [ ] Cirrhosis
- [ ] Colon polyp history
- [ ] Congestive Heart Failure
- [ ] C.O.P.D.
- [ ] Coronary Artery Disease
- [ ] Crohn's disease
- [ ] Depression
- [ ] Diabetes Mellitus, Insulin Dependent (Type 1)
- [ ] Diabetes Mellitus, Non-Insulin Dependent (Type 2)
- [ ] Diverticulitis
- [ ] Gallstones
- [ ] Gastroesophageal reflux disease (GERD)
- [ ] Gout
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] Heart Attack
- [ ] High Cholesterol
- [ ] High blood pressure
- [ ] Irritable Bowel Syndrome
- [ ] Pancreatitis
- [ ] Peptic ulcer disease
- [ ] Ulcerative Colitis
- [ ] Hypothyroidism
- [ ] Kidney disease
- [ ] Kidney stones
- [ ] Seizures
- [ ] Sleep apnea
- [ ] Stroke
- [ ] Transient Ischemic Attack
- [ ] Vascular Disease

Other: _____

Previous Procedures

- [ ] None

- [ ] Abdominal aortic aneurysm (AAA) repair
  When: _____
- [ ] Appendectomy
  When: _____
- [ ] Bilateral Tubal Ligation (BTL)
  When: _____
- [ ] Cardiac Cath - with stent placement
  When: _____
- [ ] Colon resection
  When: _____
- [ ] Gallbladder removed
  When: _____
- [ ] Coronary Artery Bypass Graft (CABG)
  When: _____
- [ ] Colonoscopy
  When: _____
- [ ] Defibrillator Placement
  When: _____
- [ ] EGD
  When: _____
- [ ] Exploratory Laparoscopy
  When: _____
- [ ] Fundoplication - Nissen
  When: _____
- [ ] Gastric Lap Band
  When: _____
- [ ] Gastric Bypass
  When: _____
- [ ] Heart valve replacement
  When: _____
- [ ] Hemorrhoidectomy
  When: _____
- [ ] Hysterectomy - Abdominal
  When: _____
- [ ] Hiatal Hernia Repair
  When: _____
- [ ] Hernia Repair - Inguinal
  When: _____
- [ ] Hernia Repair - Umbilical
  When: _____
- [ ] Hernia Repair - Abdominal Wall
  When: _____
- [ ] Joint Replacement - site unspecified
  When: _____
- [ ] Lung Lobectomy
  When: _____
- [ ] Lumpectomy Breast
  When: _____
- [ ] Mastectomy R Breast
  When: _____
- [ ] Small Bowel Resection
  When: _____
- [ ] Vasectomy
  When: _____

Other: _____

Diagnostic Studies/Tests

☐ None

☐ Abdominal Ultrasound
When:_____

☐ Blood Tests
When:_____
Other:_____

☐ CT Abdomen/Pelvis
When:_____
Other:_____

☐ CT Chest
When:_____

☐ ERCP
When:_____

☐ MRI Abdomen/Pelvis
When:_____

Allergies

☐ Patient has no known allergies

☐ Patient has no known drug allergies

☐ Adhesive Tape
☐ Aspirin
☐ Erythromycin
☐ Cephalosporins
☐ Penicillins
☐ Sulfa's
☐ Shellfish
☐ Iodine
☐ Latex
Other:_____

Other:_____

Current Medications

☐ None

Name	Dose	How taken?

Social History

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Civil Union
- ☐ Other

Alcohol

- ☐ None

Type	Quantity	Number	Frequency
☐ Beer			
☐ Wine			
☐ Hard Liquor			

Tobacco

Smoking Status

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Light tobacco smoker
- ☐ Heavy tobacco smoker
- ☐ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
☐ Cigarettes				
☐ Cigar				
☐ Chewing Tobacco				

Drug Use

- ☐ None

Type	Quantity	Number	Frequency Times / month
☐ Recreational			
☐ Street Drugs			
☐ Medications Not Prescribed to You			
☐ Marijuana			

Family Medical History

☐ No knowledge of family history

No family history of ☐ Colon Cancer

	Mother	Father	Sister	Brother	Daughter	Son
Health Status						
Alive	○	○	○	○	○	○
Deceased/At Age	○ ____	○ ____	○ ____	○ ____	○ ____	○ ____
Cause of Death	____	____	____	____	____	____
Diagnoses						
Barrett's Esophagus	○	○	○	○	○	○
Bleeding Disorders	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○
Hypertension	○	○	○	○	○	○
Lung cancer	○	○	○	○	○	○
Malignant Hyperthermia	○	○	○	○	○	○
Rectal Cancer	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Other:	○	○	○	○	○	○
Other:	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic	Y	N
Recurrent Infections	○	○

Cardiovascular	Y	N
Chest Pain	○	○
Palpitations	○	○
Swelling of Legs	○	○
Difficulty Climbing Stairs	○	○
Chest Pain When Resting	○	○
Chest Pain with Activity	○	○
Heart Murmur	○	○
Short of Breath - Exertion	○	○
Varicose Veins	○	○
High Blood Pressure	○	○

Constitutional	Y	N
Fatigue	○	○
fever	○	○
Weight Gain	○	○
Weight Loss	○	○
Chills	○	○
Night Sweats	○	○

ENMT	Y	N
Nosebleeds	○	○
Sore Throat	○	○
Runny Nose	○	○
Sinus Infection	○	○
Bleeding Gums	○	○
Dental Problems	○	○
Dentures	○	○
Hoarseness	○	○
Voice Changes	○	○
Lumps	○	○
Throat Tenderness	○	○
Thyroid Troubles or Mass	○	○

Endocrine	Y	N
Increased Thirst	○	○
Heat Intolerance	○	○
Cold Intolerance	○	○
Increased Hunger	○	○
Thyroid Trouble	○	○
Weight Gain	○	○
Weight Loss	○	○

Eyes	Y	N
Blurry Vision	○	○
Glaucoma	○	○
Vision Changes	○	○

Gastrointestinal	Y	N
Abdominal Pain	○	○
Change in Bowel Habits	○	○
Constipation	○	○
Diarrhea	○	○
Heartburn	○	○
Nausea	○	○
Vomiting	○	○
Black Tarry Stools	○	○
Blood in Stool	○	○
Hernias	○	○
Swallowing Problems	○	○

Genitourinary	Y	N
Frequent Urinary Infections	○	○
Frequent Urination	○	○
Breast Discharge	○	○
Breast Lumps	○	○
Breast Pain	○	○
Breast Tenderness	○	○
Blood in Urine	○	○
Urine - Change in Color	○	○
Incontinence	○	○
Trouble Urinating	○	○
Male Genitalia - Hernias	○	○
Male Genitalia - Pain	○	○
Male Genitalia - Prostate Problems	○	○
Male Genitalia - Scrotal Masses	○	○
Female Genitalia - Birth Control	○	○
Female Genitalia - Change in Periods	○	○
Female Genitalia - Hernias	○	○
Female Genitalia - Lesions	○	○
Female Genitalia - Menopause	○	○

Hematologic/Lymphatic	Y	N
Easy Bruisability	○	○
Anemia	○	○
Bleeding Easily	○	○
Blood Clots	○	○
Transfusion Reaction	○	○

Integumentary	Y	N
Itching	○	○
Rashes	○	○
Eczema	○	○
Major Sunburns	○	○
Mole Increased in Size	○	○
MRSA Infection	○	○
Nail Appearance Change	○	○
Skin Color Change	○	○

Musculoskeletal	Y	N
Back Problems	○	○
Joint Pain	○	○
Muscle Pain	○	○

Neurological	Y	N
Dizziness	○	○
Fainting	○	○
Headaches	○	○
Numbness	○	○
Seizures	○	○
Tremors	○	○
memory loss	○	○
Balance Difficulty	○	○
Strokes	○	○
Head Injury	○	○

Psychiatric	Y	N
Anxiety	○	○
Depression	○	○
Suicidal Thoughts	○	○

Respiratory	Y	N
Cough	○	○
Blood in Sputum	○	○
Breathing Problems	○	○

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

Yes No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

Yes No

Reviewed with

Patient Parent Guardian Not Present

Signature

Signature Date