Snow Creek Medicine, LLC
711 Barrow Street
Anchorage, AK 99501

Patient Information

Date _____ Patient Name _____ DOB _____

SSN _____ Other Name/Nickname: _____

Sex: M ☐ F ☐ Preferred Pronoun: _____ Marital Status: Single

Physical Address _____

City/State/Zip _____

Mailing Address _____

City/State/Zip _____

Home #_____ Work #_____ Cell # _____

Email: _____

How would you like to receive appointment reminders?

Text ☐ Call ☐ Email ☐ No Reminder ☐

Emergency Contact Name: _____

Emergency Contact #: _____ Emergency Contact Relation: _____

Preferred Pharmacy: _____ Preferred Lab: _____

Preferred Imaging Center: _____

Were you referred? Yes If yes, by who? _____

Insurance Information

We do not accept Medicare, Medicaid, or Worker's Comp

Primary Insurance

Insurance Name: Other If Other: _____

Subscriber ID#: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Your Relation to Subscriber: _____

Secondary Insurance

Insurance Name: Other If Other: _____

Subscriber ID#: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Your Relation to Subscriber: _____

Who is responsible for this account? _____

Patient/Guardian Signature: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices:

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____
Signature Date

Patient Financial Obligation Agreement:

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to Snow Creek Medicine for services rendered. I authorize representatives of Snow Creek Medicine to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

_____ _____
Signature Date

Medical Concerns

What is your reason for today's visit?

_____

What are your goals for today's visit and for your long-term health?

1. _____
2. _____
3. _____

What do you expect from your physician?

_____
_____

Name: _____ Date: _____ DOB: _____

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Symptoms

*Please indicate **ALL** you have experienced in the last year*

Constitutional

Fever ☐	Fatigue ☐	Weight gain: ____ lbs
Chills ☐	Feeling poorly ☐	Weight loss: ____ lbs
Sleep disturbances ☐	Sweats ☐	Unexp. weight change ☐
Other: _____		

Head, eyes, ears, nose, and throat

Vision problems ☐	Red eyes ☐	Congestion ☐	Hoarseness ☐
Decreased hearing ☐	Eye pain ☐	Snoring ☐	Ringing in ears ☐
Double vision ☐	Runny nose ☐	Dry mouth ☐	Vertigo ☐
Light sensitivity ☐	Neck stiffness ☐	Nose bleed ☐	Earache ☐
Flu-like symptoms ☐	Itchy eyes ☐	Sore throat ☐	Other: _____

Cardiovascular

Chest pain ☐	Cold extremities ☐	Irregular heart rhythm ☐
Palpitations ☐	Cold hands/feet ☐	Other: _____
Leg swelling ☐	Leg pain w/ walking ☐	

Respiratory

Shortness of breath ☐	Wheezing ☐	Coughing up sputum ☐
Cough ☐	Chest congestion ☐	Other: _____
Rapid breathing ☐	Coughing up blood ☐	

Gastrointestinal

Abdominal pain ☐	Diarrhea ☐	Change in bowels ☐	Painful swallowing ☐
Blood in stool ☐	Black/tarry stools ☐	Vomiting blood ☐	Other: _____
Vomiting ☐	Decreased appetite ☐	Bowel incontinence ☐	
Nausea ☐	Yellow skin ☐	Rectal pain ☐	
Constipation ☐	Trouble swallowing ☐	Heartburn ☐	

Neurological

Headache ☐	Unsteady ☐	Numbness ☐	Tremors ☐
Dizziness ☐	Disorientation ☐	Tingling ☐	Memory lapses/loss ☐
Decreased strength ☐	Confusion ☐	Seizures ☐	Other: _____
Poor coordination ☐	Burning sensation ☐	Fainting ☐	

Musculoskeletal

Joint Pain ☐	Limb pain ☐	Muscle Pain ☐	Other: _____
Neck Pain ☐	Joint swelling ☐	Muscle Weakness ☐	
Back Pain ☐	Muscle cramps ☐	Leg swelling ☐	

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Genitourinary

Frequent urination ☐	Pelvic pain ☐	Painful intercourse ☐	Heavy period bleeding ☐
Incontinence ☐	Nocturia ☐	Discharge – vaginal ☐	Other: _____
Urinary urgency ☐	Itching – Genital ☐	Vaginal bleeding ☐	
Painful urination ☐	Change in libido ☐	Irreg. monthly cycles ☐	

Integumentary

Rash ☐	Skin wound ☐	Unusual growth ☐	Skin cancer ☐
Dry skin ☐	Change in a mole ☐	Itching ☐	Other: _____

Endocrine

Excessive thirst ☐	Heat intolerance ☐	Changes – skin ☐	
Cold intolerance ☐	Changes – hair ☐	Other: _____	

Hematologic/Lymphatic

Easy bruising ☐ Easy bleeding ☐ Swollen lymph nodes ☐ Other: _____

Psychiatric

Depression ☐ Anxiety ☐ Other: _____

Medical History

Please list any past surgeries and hospitalizations, with their approx. date

Procedure/Hospitalization	Date	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any allergies you have

Allergy	Reaction	Allergy	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke?
Yes ☐ No ☐
If yes: How many packs a day? _____
How many years? _____

Do you use any tobacco products?
Yes ☐ No ☐

Do you use recreational drugs?
Yes ☐ No ☐
If yes: which drugs? _____

Do you consume alcohol?
Yes ☐ No ☐
If yes: How many drinks per week? _____

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Please list any medications and dosage you are currently taking

Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____

Please list any specialists you are currently seeing

Name: _____ Specialty: _____
Name: _____ Specialty: _____
Name: _____ Specialty: _____
Name: _____ Specialty: _____

Patient Information Verification

I, _____, do verify that the information above regarding my medical history is correct to the best of my knowledge.

Printed Name: _____

Signature: _____ Date: _____