



Patient Information

Date _____ Patient Name _____ DOB _____
SSN _____ Sex: M F Preferred Pronoun: _____ Marital Status: _____
Physical Address _____
City/State/Zip _____
Mailing Address _____
City/State/Zip _____
Home # _____ Work # _____ Cell # _____
Email: _____

How would you like to receive appointment reminders?

Text Email
Call No Reminder

Emergency Contact Name: _____
Emergency Contact #: _____ Emergency Contact Relation: _____
Preferred Pharmacy: _____ Preferred Lab: _____
Preferred Imaging Center: _____

Insurance Information

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

Primary Insurance

Insurance Name: _____ If Other: _____
Subscriber ID#: _____ Group #: _____
Subscriber Name: _____ Subscriber DOB: _____
Your Relation to Subscriber: _____

Secondary Insurance

Insurance Name: _____ If Other: _____
Subscriber ID#: _____ Group #: _____
Subscriber Name: _____ Subscriber DOB: _____
Your Relation to Subscriber: _____

Who is responsible for this account? _____

Patient/Guardian Signature: _____ Date: _____

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?

Symptoms

Please indicate ALL you have experienced in the last 6-12 months

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	

Name: _____ Date: _____ DOB: _____

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

<u>Procedure/Hospitalization</u>	<u>Date</u>	<u>Comments</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any allergies you have

<u>Allergy</u>	<u>Reaction</u>	<u>Allergy</u>	<u>Reaction</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Do you consume alcohol?

Yes No

If yes: How many drinks per week? _____

Name: _____ Date: _____ DOB: _____

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

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: _____