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

Patient Information

Date_____Patient Name_____DOB_____
SSN_____Sex: M F Preferred Pronoun: Marital Status: S M P D W
Mailing Address_____
City/State/Zip_____
Physical Address_____
City/State/Zip_____
Home #_____ Work #_____ Cell #_____
Email:_____

How would you like to receive appointment reminders?
(Circle): Home*Work*Cell

Employer_____Occupation:_____
Spouse/Partner Name:_____ Spouse/Parter Employer_____
Spouse/Partner Number:_____
Person to call in case of emergency_____ Phone_____

Preferred Pharmacy:_____
Preferred Imaging Center:_____
Preferred Lab:_____

Insurance Information

Primary Insurance_____ ID#_____ Grp#_____
Member Name_____ Member DOB_____
Relationship to Patient_____

Secondary Insurance_____ ID#_____ Grp#_____
Member Name_____Member DOB_____
Relationship to Patient_____

Who is responsible for this account?_____

Patient/Guardian Signature_____Date_____

Name_____ Date_____

Medical History

Past medical history (include diagnosis, date diagnosed, relevant studies/work up):

Hospitalizations (diagnosis, approx. date, treatment if relevant)

Health Maintenance: Due for annual exam___ pap___ colonoscopy___ PSA___

Family History (diagnosis, relation, age of onset, severity):

Surgical History:

Caffeine intake: **None Low Mod High**
Alcohol: **None Low Mod High**
Stress Level: **None Low Mod High**
Educational Level Achieved: _____
Smoking/Vaping: **Y N**
Drug Use: **Y N**
Living Will: **Y N**
Drug Allergies:

Environmental Allergies:

Medications:

Supplements:

Other Providers/Specialists:

Spiritual/Emotional Support:

Support/Friends/Pets:

Hobbies:

Toxic exposures:

Food allergies/sensitivities:

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

Circle preferred payment method: **Card Cash Check**
Please have your preferred payment method ready at your first appointment. Payment at the time of service for copays and deductibles is expected.

Payment Information

Card number:_____
Expiration Date:_____
Security Code:_____
Billing Zip Code:_____

I authorize Snow Creek Medicine to charge my credit card for my copays and deductibles.

_____

Signature Date

How did you hear about us? Is there anyone we can thank for referring you?

_____