1275 Sadler Way, Suite 101
Fairbanks, AK 99701
907-374-7911

Introducing Primary Care

Thank you for your interest in Steese Immediate Care's new Primary Care Service. We are excited to be your primary care provider with our exceptional, caring staff.

Please complete the attached Primary Care Information Forms. All information will be screened by your potential provider to assure that we can provide all the services that you may need. Your health and welfare is our utmost concern!

If you have a preferred Provider, please check which provider you would like to see. Some providers are more accessible than others, so your first choice may not be immediately available. If you indicate the order of preference, we will make every effort to get you in to your first choice, but will forward paperwork to your second choice for review if you would like. If you leave this blank, or do not have a preference, your Primary Care Information Forms will be forwarded to the provider with the first available appointment.

Upon review of your Health Assessment, we will contact you with information regarding possible appointment times.

Unfortunately, we are not currently enrolled in Tricare, Medicare or Medicaid

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For Clinic Use Only
_____ Date Received
_____ Date to Tracker
_____ Date to Provider
_____ Provider Approval
_____ Insurance Check
_____ Scanned to Chart
Appointment: _____@_____

Provider
Comments:_____
_____
_____
_____
_____

STEESE IMMEDIATE CARE

Patient Information Sheet

Name: _____ _____ _____ _____ Date of Birth: _____
First MI Last Suffix

Patient Registration

Address: _____
Street
_____
City, State, Zip

Gender: ☐ Male ☐ Female

Home Phone: _____

Daytime Phone: _____

Mobile Phone: _____

Social Sec. #: _____

Marital Status: ☐ Single ☐ Married

☐ Divorced ☐ Separated ☐ Widowed

Ethnic Group

☐ Decline to state ☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race

☐ African American ☐ Pacific Islander
☐ American Indian ☐ Caucasian
☐ Asian ☐ Other Race
☐ Middle-Eastern ☐ Decline to state

Guarantor

☐ Same as Patient (*if same, do not complete*)

Name: _____

Social Sec. #: _____

Address: _____
Street
_____
City, State, Zip

Patient Email

Email Required:
_____

Patient Employer

Name: _____

Address: _____
Street
_____
City, State, Zip

Emergency Contact

Name: _____

Phone: _____

Release of Information

Name: _____

Phone: _____

Insurance

Primary

Company: _____ Address: _____

Subscriber: _____ Address: _____

Subscriber Name: _____ Patient Relationship: ☐ Self ☐ Spouse ☐ Child

DOB: _____ Gender: ☐ Male ☐ Female Phone: _____

Policy Group #: _____ Individual ID: _____

Secondary

Company: _____ Address: _____

Subscriber: _____ Address: _____

Subscriber Name: _____ Patient Relationship: ☐ Self ☐ Spouse ☐ Child

DOB: _____ Gender: ☐ Male ☐ Female Phone: _____

Policy Group #: _____ Individual ID: _____

Release: I assign payment to and authorize Steese Immediate Care, LLC to file a claim with my insurance for payment of services of any government benefits due to me. I understand that if it is later determined that I am not eligible to receive benefits for these services, I will be personally responsible for payment to Steese Immediate Care, LLC.

_____ _____
Signature of Patient/ Responsible Party Date

STEESE IMMEDIATE CARE

Adult Patient Medical Questionnaire

Name: _____ _____ _____ _____ Date of Birth: _____
First MI Last Suffix

CURRENT MEDICAL PROBLEMS

List any current medical problems or conditions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

ALLERGIES

List any allergies to medication, contrast dyes or food:

Allergy	Reaction

MEDICATIONS

Preferred Pharmacy: _____

Any medication that you currently take including over-the-counter:

Name	Strength	Direction	Prescribed By

PAST MEDICAL HISTORY

Past antibiotic use:

Medication	Condition	Medication	Condition
1.		3.	
2.		4.	

Childhood Illnesses

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Chronic Illnesses

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Last Eye Exam: _____

Last Dental Exam: _____

STEESE IMMEDIATE CARE

Adult Patient Medical Questionnaire

PAST MEDICAL HISTORY (Continued)

Accidents:

	Injury	Date		Injury	Date
1.	_____	_____	4.	_____	_____
2.	_____	_____	5.	_____	_____
3.	_____	_____	6.	_____	_____

Past Surgeries:

	Surgery	Date		Surgery	Date
1.	_____	_____	4.	_____	_____
2.	_____	_____	5.	_____	_____
3.	_____	_____	6.	_____	_____

Any Other Hospital Stays:

	Reason	Date		Reason	Date
1.	_____	_____	4.	_____	_____
2.	_____	_____	5.	_____	_____
3.	_____	_____	6.	_____	_____

Anesthesia History:

Any problems with anesthesia? ☐ No ☐ Yes (If yes, please list)

_____

List Any Procedures:

	Procedure	Date		Procedure	Date
1.	_____	_____	4.	_____	_____
2.	_____	_____	5.	_____	_____
3.	_____	_____	6.	_____	_____

Physicians/ Practitioners you currently see:

	Name	Specialty		Name	Specialty
1.	_____	_____	4.	_____	_____
2.	_____	_____	5.	_____	_____
3.	_____	_____	6.	_____	_____

FAMILY HISTORY

Please check any of the following that applies:

	Mother	Father	Brother	Sister	Grandparent
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Cancer*	☐	☐	☐	☐	☐

*Please specify type/location of cancer _____

Other significant family history? (Please explain) _____

STEESE IMMEDIATE CARE

Adult Patient Medical Questionnaire

SOCIAL HISTORY

Do you drink alcohol? ☐ No ☐ Yes
If yes, how much? _____
Are you sexually active? ☐ No ☐ Yes
If yes, what form of contraception do you use?: _____
Do you consume caffeine? ☐ No ☐ Yes
If so, how much per day? _____
Diet: ☐ Balanced ☐ Vegetarian ☐ Diabetic ☐ Low Salt ☐ Low Fat ☐ Low Carb ☐ Other: _____
Have you ever been in an abusive relationship? ☐ No ☐ Yes
Are you afraid of your partner? ☐ No ☐ Yes
Education: ☐ High School ☐ College ☐ Some College ☐ Trade School ☐ Other: _____
Do you do some form of regular exercise every day? ☐ No ☐ Yes
If yes, how much? _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____

Occupation: _____
Place of birth (City, State): _____
Have you lived abroad more than one month? ☐ No ☐ Yes If yes, where? _____
List everyone in your household, including pets:
_____ _____
_____ _____
_____ _____
Do you wear seatbelts? ☐ No ☐ Yes
Do you participate in activities that put you at risk of getting AIDS? ☐ No ☐ Yes
Do you smoke or chew tobacco? ☐No ☐ Yes
If yes, how much? _____
Spouse's occupation: _____
Do you use recreational drugs: ☐ No ☐ Yes
If yes, what do you use? _____

HEALTH MAINTENANCE

Please record the last year you had the following. If you do not know, leave blank.

HepA_____
HepB_____
Flu vaccine (shot)_____
Pneumonia vaccine (shot)_____
Tuberculosis Test_____
Positive PPD_____
Tetanus Diphtheria vaccine (shot)_____
TdaP_____
Meningococcal_____
MMR_____
Zostavax_____

Bone Density Scan_____
Breast Exam_____
Cardiac Stress Test_____
Colonoscopy_____
EKG_____
Hearing Exam_____
Mammogram_____
Eye Exam_____
Pelvic Exam_____
PAP Smear/GYN_____
Physical Exam_____

MENSTRUAL HISTORY

Date of last menstrual period: _____
Amount: ☐ Normal ☐ Light ☐ Heavy ☐ Other: ____
Duration: _____ days
Are periods regular? ☐ No ☐ Yes
How many days apart are periods? _____
Age of onset periods: _____
Age of cessations of periods: _____
Any abnormal PAP smears? ☐ No ☐ Yes
If yes, when _____
Diagnosed with any STI's ☐ No ☐ Yes
If yes, what _____

PAST PREGNANCIES

Please note the number of pregnancies:
Total Pregnancies: _____
Full term births: _____
Premature births: _____
Abortions – induced: _____
Abortions – spontaneous: _____
Pregnancies – Ectopic: _____
Pregnancies – Multiple births: _____
Living: _____

STEESE IMMEDIATE CARE

Adult Patient Medical Questionnaire

REVIEW OF SYSTEMS

Please check if you have had problems with or are presently experiencing problems with any of the following:

Skin
- ☐ Skin diseases

Eyes
- ☐ Eye diseases

ENT
- ☐ Hay fever
- ☐ Head or neck

Neck
- ☐ _____

Respiratory
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Pneumonia
- ☐ Persistent cough

Cardiovascular
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Chest pain
- ☐ Swollen ankles
- ☐ Palpitations
- ☐ Lightheadedness

Gastrointestinal
- ☐ Abdominal discomfort
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Ulcers
- ☐ Change in bowel habits
- ☐ Unexplained weight gain/loss
- ☐ Hemorrhoids
- ☐ Gall bladder disease
- ☐ Colitis

Genitourinary (Female)
- ☐ Frequent urination
- ☐ Kidney diseases
- ☐ Kidney stones
- ☐ Difficulty urinating

Genitourinary (Male)
- ☐ Frequent urination
- ☐ Kidney diseases
- ☐ Kidney stones
- ☐ Difficulty urinating

Musculoskeletal
- ☐ Arthritis
- ☐ Low back problems
- ☐ Gout

Neurological
- ☐ Headache

Endocrine
- ☐ Diabetes
- ☐ Thyroid Disease

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Alcohol Abuse
- ☐ Drug Abuse

Hematologic/ Oncologic
- ☐ Cancer
- ☐ Blood Disorders
- ☐ Anemia

Infectious Disease
- ☐ Venereal Disease
- ☐ Hepatitis or Jaundice
- ☐ TB
- ☐ Rheumatic fever

OTHER

Do you have an advanced directive (living will)? ☐ No ☐ Yes

Notes: _____

_____

_____

Patient/Guardian Signature: _____ Date: _____

Reviewed By: _____ Date: _____