1275 Sadler Way, Suite 101 B
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.

____ Kristina Ufimtseva, FNP
____ Matija Meenaghan, PA-C

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:_____
_____
_____
_____
_____

Adult Patient Medical Questionnaire

Patient Financial Policy
Please read all sections prior to signing the bottom sections

Patient Name_____ **Today's Date** _____ **DOB** _____

Thank you for choosing Steese Immediate Care for your immediate care needs. We strive to establish and maintain a positive relationship with all of our patients. Your clear understanding of our Patient Financial Policy is important to that relationship. We welcome and encourage you to ask questions regarding these policies and all other aspects of your visit with us, especially if those questions can help to resolve concerns you may have.

_____ **(Initials)**

Co-pays/Deductibles

Insurance cards should be presented at every visit. Co-payments, deductibles and past due balances are due at time of service, unless previous arrangements have been made with a billing coordinator.

_____ **(Initials)**

Insurance Claims- *Please see above policy regarding Co-pays/Deductibles*

As a courtesy to you, we will bill all commercial insurance carriers with whom you carry a plan. In order to properly bill your insurance, we require that you disclose all insurance information including primary, secondary, or workers' compensation. Failure to provide complete information may result in all charges transferring to the responsible party. Although we may ***ESTIMATE*** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. You will be responsible for any portion of the charges the carrier does not cover or pay. If your insurance carrier pays you directly, you are responsible for payment and by signing below you agree to forward the payment to us immediately. Payments made directly to you, from your insurance, are due 30 days from **our** receipt of the EOP (estimation of payment).

_____ **(Initials)**

Self-pay Accounts- *Payment is due at the time of service.*

Self-pay accounts are individuals without insurance coverage, do not provide our office with insurance information or patients with insurance plans that we do not bill directly.

_____ **(Initials)**

Outstanding Balance Policy

It is our office policy that all guarantors be sent **four (4)** statements, each preceded by **one (1)** phone call. If no payment is made and balances become past due, interest will be applied to the principal balance in accordance with state law, ***AS 45.45.010***. As a courtesy, we will attempt **one (1)** final phone call followed by a final letter to remind you of our right to send the account to collections. If no resolution can reached, the account will be sent to the collection agency. ***In the event an account is turned over for collections, the guarantor will be responsible for all collections costs paid directly to the collection agency.***

_____ **(Initials)**

Outgoing Laboratory Authorization

I hereby authorize the release of medical information related to any possible service described hereon and authorize payment directly to the outgoing laboratory that Steese Immediate Care deems necessary. I agree to assume responsibility for payment of charges for laboratory services that are not covered by my healthcare insurer.

HMO POLICY HOLDERS: You are responsible for calling your primary providers and your carrier for referrals or authorizations. Without these, you will be treated as self-pay until they have been obtained.

MEDICARE, MEDICAID, & TRICARE: We, as a clinic, are not enrolled with Medicare, Medicaid & Tricare and cannot bill these insurances. (If Medicare and Medicaid are secondary to a private insurance, please ask about our self-pay options)

****We do not bill Motor Vehicle Insurance****

****We do not bill FEDERAL Workers Compensation** **We do not bill out-of-state workers compensation.****

I hereby authorize Steese Immediate Care to bill my insurance, as provided, and to receive payment from my insurance on my behalf. Furthermore, I authorize the release of medical information to my insurance carrier for the payment of claims.

_____ _____

Signature of Patient/Responsible Party **Date**

PATIENT QUESTIONNAIRE/REVIEW OF SYSTEMS

Name_____ Today's date_____ DOB_____

IN THE LAST <u>TWO WEEKS</u> HAVE YOU EXPERIENCED THE FOLLOWING? Please circle yes or no to all questions.

<u>CONSTITUTIONAL</u>

Good general health lately_____ Yes No
Recent weight change_____ Yes No
Fever_____ Yes No
Fatigue_____ Yes No
Headaches_____ Yes No

<u>EYES</u>

Eye disease or injury_____ Yes No
Wear glasses or contacts_____ Yes No
Blurred or double vision_____ Yes No
Glaucoma_____ Yes No

<u>ENT</u>

Hearing loss_____ Yes No
Ringing in ears_____ Yes No
Earaches or drainage_____ Yes No
Sinus problems_____ Yes No
Nose bleeds_____ Yes No
Mouth sores_____ Yes No
Bleeding gums_____ Yes No
Bad breath or bad taste_____ Yes No
Sore throat or voice change_____ Yes No
Swollen glands in neck_____ Yes No

<u>CARDIOVASCULAR</u>

Heart trouble_____ Yes No
Chest pains_____ Yes No
Sudden heart beat changes_____ Yes No
Swelling of feet, ankles, hands_____ Yes No

<u>RESPIRATORY</u>

Frequent coughing_____ Yes No
Spitting up blood_____ Yes No
Shortness of breath_____ Yes No
Asthma or wheezing_____ Yes No

<u>GASTROINTESTINAL</u>

Loss of appetite_____ Yes No
Change in bowel movements_____ Yes No
Nausea or vomiting_____ Yes No
Frequent diarrhea_____ Yes No
Painful bowel movements_____ Yes No
Constipation_____ Yes No
Blood in stool_____ Yes No
Stomach pain_____ Yes No

<u>PSYCHIATRIC</u>

Memory loss or confusion_____ Yes No
Sleep problems_____ Yes No
Nervousness_____ Yes No
Depression_____ Yes No

<u>MUSCULOSKELETAL</u>

Joint pain_____ Yes No
Joint stiffness or swelling_____ Yes No
Weakness of muscles or joints _____ Yes No
Muscle pain or cramps_____ Yes No
Back pain_____ Yes No
Cold extremities_____ Yes No
Difficulty walking_____ Yes No

<u>SKIN</u>

Rash or itching_____ Yes No
Change in skin color_____ Yes No
Change in hair or nails _____ Yes No
Varicose veins_____ Yes No
Breast pain_____ Yes No
Breast lump_____ Yes No
Breast discharge_____ Yes No

<u>NEUROLOGICAL</u>

Frequent or recurring headaches_____ Yes No
Light headed or dizzy_____ Yes No
Convulsions or seizures_____ Yes No
Numbness or tingling sensations_____ Yes No
Tremors_____ Yes No
Paralysis_____ Yes No
Stroke_____ Yes No

<u>ENDOCRINE</u>

Glandular or hormone problems_____ Yes No
Thyroid Disease_____ Yes No
Excessive thirst or urination_____ Yes No
Heat or cold intolerance_____ Yes No
Dry skin_____ Yes No

<u>HEMATOLOGICAL/LYMPATHIC</u>

Slow to heal after cuts_____ Yes No
Bruise or bleed easily_____ Yes No
Anemia_____ Yes No
Phlebitis_____ Yes No
Past transfusions_____ Yes No
Enlarged glands_____ Yes No

<u>GENITOURINARY</u>

Frequent urination_____ Yes No
Burning or painful urination_____ Yes No
Blood in urine_____ Yes No
Change in force of strain when urinating___ Yes No
Incontinence or dribbling_____ Yes No
Kidney stones_____ Yes No

Patient Information Sheet

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

Patient Information

Address: _____
Street
_____
City, State, Zip
Sex: ☐ Male ☐ Female
Home Phone: _____
Daytime Phone: _____
Mobile Phone: _____
Social Sec. #: _____
Marital Status: ☐ Single ☐ Married
☐ Divorced ☐ Separated ☐ Widowed

Communication Preference

☐ Text ☐ Phone Call ☐ Email
☐ Detailed Messages OK
☐ Consent to send & receive info through text

Release of Information

Name: _____
Phone: _____
☐ Detailed Messages OK

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: _____
☐ Detailed Messages OK

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

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: _____

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) _____

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: _____

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: _____