anchorage medical services

3401 Minnesota Drive Ste 100
Anchorage, AK 99503
P. 907-677-9200
F. 907-677-9210

Patient Registration

First Name: _____ MI:_____ Last Name: _____

Date of Birth: _____ Sex: (*Circle*) M F Social Security Number: _____ - ____ - _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____ (*Circle*) Cell Home Work Other: _____

Alternative Phone Number: _____ (*Circle*) Cell Home Work Other: _____

May we leave a detailed voice message on your phone? (Circle) Yes No

E-Mail Address: _____

FOR MINORS (please list BOTH parents/guardians):

Parent/Guardian 1 Name: _____ DOB: _____ Relationship: _____

Parent/Guardian 2 Name: _____ DOB: _____ Relationship: _____

Whom should we contact in the case of an emergency?

First and Last Name: _____ Relationship: _____

Telephone: _____ (*Circle*) Cell Home Work Other

How did you hear about our practice? (Circle)

Sign Internet Search Friend/Relative Social Media Other: _____

Is your visit related to a work injury? (*Circle*) Yes No Is your visit related to a motor vehicle accident? (*Circle*) Yes No

Primary Insurance Information

Insurance Company Name: _____ Employer:_____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder Date of Birth: _____ Policy Holder Social Security Number: _____ - ____ - _____

Secondary Insurance Information

Insurance Company Name: _____ Employer:_____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder Date of Birth: _____ Policy Holder Social Security Number: _____ - ____ - _____

Is there anyone we can speak to regarding your account and medical care?

First and Last Name: _____ Relationship: _____

Form Completed by (Print): _____ Relationship to Patient: _____

Patient or Guarantor Signature: _____ Date: _____

Staff Reviewer Initials: _____

Medical History

Patient Name:_____ DOB:_____

Gender: (Circle One) M F

Primary Care Physician:_____

Preferred Pharmacy:_____

Chief Complaint:_____

Previous Medical History:_____

Previous Surgeries (Date/Type): _____

Medication Allergies: (Specify medication and reaction): _____

_____

Please list your current medications including over the counter and herbal supplements.

Name	*Dosage Per Day*	*Reason*

Please notify the front desk if you need an additional form to list medications or medical history.

Family History

(Specify Relationship)

Cancer:	Yes / No _____	Arthritis:	Yes / No _____
Heart Disease:	Yes / No _____	High Blood Pressure:	Yes / No _____
Bleeding Problems:	Yes / No _____	Osteoporosis:	Yes / No _____
Diabetes:	Yes / No _____	Other:_____	

Social History

Employment Status (*Circle*): Employed Unemployed Student Retired Minor

Do you currently/have you previously used tobacco products? Yes / No
Please specify product: (*Circle*) Cigarettes / Chew Other: _____

Do you use alcohol? Yes / No How many drinks per week do you have? _____

Do you use any recreational drugs? Yes / No If "Yes" please specify: _____

Females

Are you currently pregnant? Yes / No Weeks / Due Date: _____
Are you currently breastfeeding? Yes / No

Date of last menstrual cycle: _____ *Staff Reviewer Initials:* _____

Have you experienced any of the following? Please address each of the items below.

NO	LAST MONTH	NOW	GENERAL
☐	☐	☐	Weight Loss or Gain
☐	☐	☐	Fatigue
☐	☐	☐	Fever/Chills
☐	☐	☐	Weakness
☐	☐	☐	Trouble Sleeping
☐	☐	☐	Decline in Health
			RESPIRATORY
☐	☐	☐	Cough
☐	☐	☐	Sputum
☐	☐	☐	Coughing Up Blood
☐	☐	☐	Shortness of Breath
☐	☐	☐	Wheezing
☐	☐	☐	Painful Breathing
			HEAD
☐	☐	☐	Headache
☐	☐	☐	Head Injury
☐	☐	☐	Dizziness
			GASTROINTESTINAL
☐	☐	☐	Difficulty Swallowing
☐	☐	☐	Heartburn
☐	☐	☐	Decreased Appetite
☐	☐	☐	Nausea/Vomiting
☐	☐	☐	Bowel Habit Changes
☐	☐	☐	Rectal Bleeding
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Abdominal Pain
			MUSCULOSKELETAL
☐	☐	☐	Muscle/Joint Pain
☐	☐	☐	Stiffness
☐	☐	☐	Back Pain
☐	☐	☐	Swelling of Joints
☐	☐	☐	Injury/Trauma
☐	☐	☐	Arthritis
☐	☐	☐	Restricted Motion
			HEMATOLOGIC/LYMPH
☐	☐	☐	Ease of Bruising
☐	☐	☐	Ease of Bleeding
☐	☐	☐	Anemia

NO	LAST MONTH	NOW	SKIN
☐	☐	☐	Rashes
☐	☐	☐	Lumps
☐	☐	☐	Itching
☐	☐	☐	Dryness
☐	☐	☐	Hair/Nail Changes
☐	☐	☐	Injury/Trauma
☐	☐	☐	Burn
			NOSE
☐	☐	☐	Stuffiness
☐	☐	☐	Discharge
☐	☐	☐	Itching
☐	☐	☐	Loss of Smell
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus Pain
☐	☐	☐	Sneezing
			PSYCHIATRIC
☐	☐	☐	Stress
☐	☐	☐	Mood Changes
☐	☐	☐	Behavioral Changes
☐	☐	☐	Depression
☐	☐	☐	Disorientation
☐	☐	☐	Hallucinations
☐	☐	☐	Nervousness
			NECK
☐	☐	☐	Swollen Glands
☐	☐	☐	Pain
☐	☐	☐	Stiffness
			EYES
☐	☐	☐	Vision Loss or Changes
☐	☐	☐	Glasses/Contacts
☐	☐	☐	Pain
☐	☐	☐	Redness
☐	☐	☐	Blurry/ Double Vision
☐	☐	☐	Pain with Light
☐	☐	☐	Recent Injury
☐	☐	☐	Itching
			BREASTS
☐	☐	☐	Lumps
☐	☐	☐	Pain
☐	☐	☐	Discharge

NO	LAST MONTH	NOW	THROAT/MOUTH
☐	☐	☐	Bleeding
☐	☐	☐	Dry Mouth
☐	☐	☐	Sore Throat
☐	☐	☐	Hoarseness
☐	☐	☐	Loss of Taste
☐	☐	☐	Post Nasal Drip
			EARS
☐	☐	☐	Decrease Hearing
☐	☐	☐	Ringing
☐	☐	☐	Earache
☐	☐	☐	Drainage
			GENITOURINARY
☐	☐	☐	Frequency
☐	☐	☐	Urgency
☐	☐	☐	Burning/Pain
☐	☐	☐	Blood in Urine
☐	☐	☐	Incontinence
☐	☐	☐	Urine Odor
☐	☐	☐	Abnormal Discharge
☐	☐	☐	Change in Sexual Function
			ENDOCRINE
☐	☐	☐	Heat/Cold Intolerance
☐	☐	☐	Sweating
☐	☐	☐	Increased Thirst
			NEUROLOGIC
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Seizures
☐	☐	☐	Numbness
☐	☐	☐	Tingling
☐	☐	☐	Tremor
☐	☐	☐	Unsteady Gait
☐	☐	☐	Burning
☐	☐	☐	Memory Loss
			CARDIOVASCULAR
☐	☐	☐	Chest Pain
☐	☐	☐	Tightness
☐	☐	☐	Palpitations
☐	☐	☐	Shortness of Breath w/ Activity
☐	☐	☐	Difficulty Breathing Lying Down
☐	☐	☐	Swelling
☐	☐	☐	Leg Pain - Walking

☐ I have **NONE** of these issues.

Form Completed by (Print): _____ Relationship to Patient: _____

Patient or Guardian Signature: _____ Date: _____

Staff Reviewer Initials: _____

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Patient Name: _____

Please **initial** next to each statement below.

_____ I understand that I am financially responsible for all charges incurred by my dependent or myself at the time of service. I agree to pay all amounts determined as patient responsibility as well as any fees associated with services rendered, including collections costs.

_____ I authorize my insurance company(s) to pay AMS Urgent Care for those charges that are filed by the clinic on my behalf.

_____ I understand AMS Urgent Care bills out as a primary care specialist. This is a financial benefit to the majority of our patients. We will provide you with an explanation of your benefits and a cost estimate prior to being seen.

_____ In the event that payment is issued to me by my insurance company for treatment/services received at AMS Urgent Care any amount up to the balance on my account will be immediately remitted to AMS Urgent Care.

_____ I authorize AMS Urgent Care to release any medical information required by my insurance company, worker's compensation or auto insurance carrier for the processing of any medical claims on my behalf.

_____ I have read and signed the AMS Urgent Care Financial Policy.

_____ I acknowledge that I have been provided a copy of AMS Urgent Care Notice of Privacy Practices which describes how my medical information may be used and disclosed.

Do you receive **Medicare** benefits of any kind? This includes "Part A" for hospital benefits. ☐ Yes ☐ No

_____ By initialing here I certify that *I DO NOT* receive **Medicare** benefits.

PLEASE NOTE THAT MEDICARE IS *DIFFERENT* FROM **MEDICAID** OR **DENALI CARE.**

Form Completed by (Print): _____ Relationship to Patient: _____

Patient or Guarantor Signature: _____ Date: _____

Staff Reviewer Initials: _____

Financial Policy

Welcome to AMS Urgent Care. We are pleased that you have chosen our practice for your medical needs. We ask that you carefully read and sign the following statement. We must emphasize that, as your medical care provider, our relationship is with you and not your insurance carrier. As a courtesy to you we will file your claim with your insurance company. However, you are the sole responsible party for all charges incurred and guarantee payment. If we are contracted with your insurance company, we will accept assignment. You are responsible for your payment portion at the time of service. Failure to provide current, accurate billing information will result in all charges for service becoming the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and responsibilities. *All copays, co-insurance, and deductibles are due and payable at the time services are rendered.*

For patients not covered by insurance that are able to pay their bill in full by cash or credit card on the date of service we may be able to offer discounted rates on office visits, diagnostic testing and durable medical equipment. Our office requires $220 prior to visit made by cash or credit card to see the provider and any remainder balance due for diagnostic testing and durable medical equipment at the end of the visit.

Worker's Compensation:
We are able to bill your employer's worker's compensation insurance company for injuries occurring while on the job in Alaska when the patient provides the front desk with a copy of the Report of Injury filed with their employer as well as the appropriate contact information for the employer and all claim information the patient has at that time. Ultimately it is the patient's responsibility to ensure we have complete information to bill in a timely manner. If we do not receive accurate billing information within 30 days from date of service the bill will become patient responsibility. Unfortunately, we are unable to bill Federal Worker's Compensation and patient will need to seek treatment elsewhere.

Automobile Accidents:
We are able to submit medical claims to personal auto insurance carriers for patient's recently injured in a motor vehicle accident that have an open claim with MedPay available for treatment. The patient is required to provide the front desk with complete claim and billing information when checking in for an appointment. We do not deal with Third Party claims. In the instance that a patient seeks care for injuries sustained in a motor vehicle accident and does not have a personal policy with MedPay available, payment is due in full at the time of service.

Medicare: We do not accept Medicare at this time.

Medicaid: We do not accept out of state Medicaid. Any voluntary procedures, or procedures deemed by Medicaid as not medically necessary, will be the patient's responsibility. Patients over the age of 18 will be responsible for their $3.00 co-pay at the time of visit.

Refunds: If an overpayment has occurred a refund check will be issued within 30 days from the final receipt of payment from your insurance company.

We accept payment in the form of cash, credit/debit card, and cashier's check. We do not accept personal checks.

In consideration of the services performed by AMS Urgent Care, you agree to abide by the terms of this financial statement:

Print Name: _____ Relationship to Patient: _____

Patient or Guardian Signature: _____ Date: _____

Staff Reviewer Initials: _____