



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: _____ Policy Holder: _____

Policy Holder Date of Birth: _____ Relationship to Patient: _____

Policy/ID Number: _____ Group Number: _____

Secondary Insurance Information

Insurance Company: _____ Policy Holder: _____

Policy Holder Date of Birth: _____ Relationship to Patient: _____

Policy/ID Number: _____ Group 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/Guardian Signature: _____ Date: _____

_____ Staff Review Initials

Medical History

It is important that you complete all parts of the medical history form to the best of your ability.

Patient Name: _____ Preferred Name: _____ DOB: _____

Gender: M / F Primary Care Provider: _____ Preferred Pharmacy: _____

Reason for Visit Today: _____

Medical History: _____

Previous Surgeries (Date/Type): _____

Medication Allergies: _____
(Specify Mediation and Reaction)

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

<i>Medication</i>	<i>Dosage Per Day</i>	<i>Reason</i>

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: Minor Student Retire Unemployed Employed - Occupation: _____

Tobacco Use: Current / Previously / No Please Specify Produce: Cigarettes / Chew Other: _____

Alcohol Use: Yes / No Please Specify Product: Beer / Wine / Hard Liquor How many drinks per week? _____

Recreational Drug Use: Yes / No If "Yes" please specify: _____

Females

Date of last menstrual cycle: _____ Birth Control: Yes / No Type of Birth Control: _____

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

_____ Staff Review Initials

Have you experienced any of the following?

Please address ALL the items below

General

Last			
No	Month	Now	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss or Gain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever/Chills
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Sleeping
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decline In Health

Respiratory

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sputum
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coughing Up Blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Breathing

Head

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness

Gastrointestinal

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Burn
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Appetite
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Habit Changes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain

Musculoskeletal

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Joint Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Joints
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Injury/Trauma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restricted Motion

Hematologic/Lymph

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ease of Bruising
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ease of Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia

SKIN

Last			
No	Month	Now	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumps
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair/Nail Changes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Injury/Trauma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burn

Nose

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness/Congestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Smell
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing

Psychiatric

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stress
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood Changes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Changes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disorientation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness

Neck

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness

Eyes

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision Loss or Changes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glasses/Contacts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Redness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurry/Double Vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain with Light
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent Injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching

Breasts

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumps
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discharge

Throat/Mouth

Last			
No	Month	Now	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Taste
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post Nasal Drip

Ears

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decrease Hearing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drainage

Genitourinary

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequency
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urgency
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning/Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urine Odor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change In Sexual Function

Endocrine

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heat/Cold Intolerance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased Thirst

Neurologic

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tingling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unsteady Gait
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss

Cardiovascular

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tightness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath w/ Activity
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing lying down
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain with Walking

Form Completed by (Print): _____

Relationship to Patient: _____

Patient/Guardian Signature: _____

Date: _____

Anchorage Medical Services dba AMS Urgent Care Financial Policy & Patient Agreement

Welcome to Anchorage Medical Services. Please take a moment to carefully review our Financial Policy. By signing, you acknowledge that you have read, understood, and agree to the terms outlined below.

Patient Financial Responsibility

AMS Urgent Care's relationship is with you, the patient, not your insurance carrier. While we may submit claims on your behalf as a courtesy, you are ultimately responsible for all charges incurred.

By receiving services, you agree to the following:

- All copays, coinsurance, and deductibles are due at the time of service.
 - If we are contracted with your insurance carrier, we will accept assignment per contract terms.
- Any remaining balance not covered by your insurance is your responsibility.
- Services deemed not medically necessary or not covered by your insurance plan are your responsibility.
- Providing complete and accurate insurance information is your responsibility; failure to do so may result in full personal financial responsibility.

Accounts not paid within 90 days may be referred to collections. You agree to pay reasonable collection costs, administrative fees, and returned check or chargeback fees as permitted under Alaska law.

Insurance Participation & Network Status

AMS Urgent Care participates with select insurance plans. Participation may change at any time. Eligibility and Benefits are determined by your plan. Verification by AMS is a courtesy, not a guarantee.

Current networks include:

- UnitedHealthcare
- Premera Blue Cross Blue Shield Networks
- Aetna Networks
- MODA
- Alaska State Medicaid

In-Network claims are submitted per our contracts. Out of Network claims may be submitted as a courtesy; full payment may be required at the time of service.

Insurance Billing & Place of Service

AMS bills under POS 11 – Office, in accordance with our enrollment and contracts. Some insurers may process claims differently than POS 20 (Urgent Care Facility), affecting copays, coinsurance, or deductible calculations. Cost estimates are provided as a courtesy and are not a guarantee of payment. Billing cannot be altered to change insurance processing or payment outcomes.

Minor Patients & Guarantor Responsibility

Parents, guardians, or legal representatives accompanying a minor are financially responsible for all services, regardless of custody arrangements or divorce decrees.

Self-Pay Patients

Full payment is due at the time of service. Discounted self-pay rates may be available.



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Medicare

Medicare is administered by the Centers for Medicare & Medicaid Services (CMS). AMS does not bill Medicare and is not a participating provider for Medicare Part B. AMS does not provide inpatient hospital services and does not bill Medicare Part A. Some AMS providers have formally opted out of Medicare Part B in accordance with CMS regulations and see patients on a cash-pay basis only.

Medicaid

We only accept Alaska State Medicaid, aka. Denali Kid Care, Out-of-state Medicaid is not accepted. Patients over 18 are responsible for their copay at the time of visit. Voluntary procedures or services deemed not medically necessary are patient responsibility.

Worker's Compensation

AMS Urgent Care can bill Alaska Worker's Compensation when a Report of Injury have been filed, and the injury is verified with your employer. Complete billing information, including claim number, adjusting company, adjuster name and phone, and the correct date of injury must be provided within 10 days of treatment. If complete billing information is not provided within this timeframe, charges will become patient's responsibility and accounts not paid within 90 days may be referred to collections

Federal or out-of-state Worker's Compensation claims cannot be billed.

Automobile Accidents

AMS Urgent Care accepts auto accident injuries that occurred in the state of Alaska. If MedPay coverage is available through auto insurance, it must submitted prior to billing medical insurance.

Patients must provide complete claim information at check-in, including:

- Claim number
- Insurance company name
- Adjuster contact information

AMS does not bill third-party liability claims. If no applicable MedPay coverage or medical insurance is available, payment in full is due at the time of services. Patients are responsible for providing complete and accurate claim information; failure to do so may result in full personal financial responsibility.

Overpayments and Refunds

Overpayments will be refunded within 30 business days after final insurance payment or once the account shows a credit balance. Refunds are issued by check only. Credits under \$10.00 will remain as a credit on file for future services unless a refund request is made by the patient. Patients are responsible for ensuring their address on file is current to avoid delays.

Acknowledgement and Signature

I acknowledge that I have received, read, and understand the AMS Urgent Care Financial & Insurance Policy. I acknowledge that I have been provided a copy of AMS Urgent Care's Notice of Privacy Practices, which explains how my medical information may be used and disclosed. I agree to be responsible for payment of all services rendered, as outlined above.

Patient Name (Printed): _____

Date of Birth: _____

Signature: _____

Today's Date: _____

_____ *Staff Review Initials*

Anchorage Medical Services dba AMS Urgent Care Medicare Policy and Patient Acknowledgment

Medicare Overview

Medicare is administered by the Centers for Medicare & Medicaid Services (CMS):

- **Part A:** Hospital (inpatient) coverage
- **Part B:** Outpatient and professional medical services

AMS Medicare Policy

- AMS Urgent Care does not provide inpatient hospital services and does not bill Medicare Part A.
- AMS is not a participating provider for Medicare Part B and therefore cannot accept Medicare Part B.
 - Certain AMS providers have opted out of Medicare Part B in accordance with CMS regulations and may accept patients on a cash-pay basis only.
 - Medicare will not reimburse services provided by opted-out providers.
 - Neither AMS nor the patient may submit claims to Medicare for services provided by an opted-out provider.
- Patients are responsible for full payment at the time of service.
- Failure to disclose Medicare coverage may result in full personal financial responsibility.

Please initial one:

_____ *I do not have Part B Medicare coverage*

_____ *I have Medicare Part B coverage, and I am voluntarily choosing to receive services from an AMS provider who has opted out of Medicare. I understand:*

- Medicare will not be billed.
- Medicare will not reimburse me for services.
- I am responsible for full payment at the time of service.

Acknowledgement and Signature

I certify that the Medicare information I have provided is accurate and complete. I understand that knowingly providing false information may constitute **Medicare fraud** under federal law.

Patient Name (Printed): _____

Date of Birth: _____

Signature: _____

Today's Date: _____

_____ *Staff Review Initials*