alaska oncology
AND HEMATOLOGY, LLC

2925 DeBarr Road, Suite 300 • Anchorage, AK 99508
Phone: 907-279-3155 • Fax: 907-279-3154

Date _____

Patient Information

Patient Name: _____ D.O.B. ____/____/____ SSN: _____-_____-_____

Mailing Address: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Hm Phone: _____ Wk Phone: _____ Cell Phone: _____

Local Phone: _____ Can we leave a message on your recorder? O Yes O No

Employer: _____ Occupation: _____

Referring Physician: _____

Do you have a hospital preference? _____ Pharmacy? _____

Parent/Legal Guardian (if not patient): _____

Marital Status: O Married O Single O Widowed O Divorced Sex: O Male O Female

If married, spouse's name: _____ May we contact? O Yes O No

Emergency Contact(s):

Name _____ Phone: _____ Relationship: _____

Name _____ Phone: _____ Relationship: _____

Name _____ Phone: _____ Relationship: _____

Insurance Information

Primary Insurance

Insurance: _____ Ins. Phone: _____

Policy Holder: _____ Policy Holder's SSN: _____-_____-_____

Policy #: _____ Group #: _____

Policy Holder's D.O.B. ____/____/____ Policy Holder's Employer: _____

Secondary Insurance

Insurance: _____ Ins. Phone: _____

Policy Holder: _____ Policy Holder's SSN: _____-_____-_____

Policy #: _____ Group #: _____

Policy Holder's D.O.B. ____/____/____ Policy Holder's Employer: _____

Tertiary Insurance

Insurance: _____ Ins. Phone: _____

Policy Holder: _____ Policy Holder's SSN: _____-_____-_____

Policy #: _____ Group #: _____

Policy Holder's D.O.B. ____/____/____ Policy Holder's Employer: _____

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FINANCIAL POLICY

Patient Name: _____

Thank you for choosing us as your health care provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Our practice believes that a good provider-patient relationship is based on understanding and good communication. The following is a statement of our Financial Policy, which we require that you read and sign before any treatment.

Our practice accepts most major insurance companies. All patients must complete our patient registration form and give us the necessary information before seeing a provider.

We require payment of your deductible, or your co-payment, at the time of service, unless other arrangements have been agreed upon. We accept cash, personal checks, MasterCard, Visa and American Express.

You are responsible for any portion of your bill that your insurance carrier denies or does not cover. Your insurance coverage is a contract between you and your insurance carrier; however, we are available to assist you in maximizing your insurance benefits.

Please be aware that few insurance companies attempt to cover all medical costs. Some pay fixed allowances for each procedure while others pay only a percentage of the costs. Many insurance companies use a fee schedule derived from providers outside this region and that may not be applicable for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Returned checks are subject to additional collection fees. Charges may also be made for broken appointment and appointments canceled without 24 hours advance notice.

If you have any questions concerning our Financial Policy, or if this creates undue hardship, please contact our Reimbursement Specialist, Denice Demeris at (907) 279-9827 immediately to discuss special arrangements.

By signing below, I verify that I have read and understand this Financial Policy and I authorize Alaska Oncology and Hematology, LLC to release medical records to my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Alaska Oncology and Hematology, LLC if not paid in full at the time of service. I agree that a reproduced copy of this authorization will be as valid as the original. I understand I am responsible for any amount not covered by my insurance.

_____ _____

Signature of patient or responsible party Date

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Mary Stewart, M.D
Verneeda Spencer, M.D
Max Rabinowitz, M.D
Steven Liu, M.D
Zach Zipsir, PA-C

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Anchorage, Alaska 99508
Telephone: 907-279-3155
Fax: 907-279-3154

YOUR RIGHT TO PRIVACY

PATIENT NAME_____ DATE OF BIRTH_____

If you'd like to share your information with your spouse, partner, significant other, friend, or family members, list them below:

_____

_____

PLEASE NOTE: THESE WILL BE THE ONLY PEOPLE BESIDES YOURSELF WHO ARE ABLE TO RECEIVE INFORMATION ABOUT YOUR CONDITION.

We respect your right to privacy regarding, medical information. Without additional written consent we cannot share your information. Please keep in mind; you are responsible to update this form with any changes. This form is valid until otherwise notified by you in writing.

WE need YOUR permission to send electronic prescriptions, to receive electronic prescription refill request and to download prescription history as necessary.

☐ YES ☐ NO

ACKNOWLEDGEMENT
NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge
receipt of the Alaska Oncology and Hematology, LLC
Notice of Privacy Practices.

_____ _____

PATIENT SIGNATURE Date

Alaska Oncology and Hematology is researching new methods of prevention, diagnosis and treatment of cancer. By signing below I authorize a protocol nurse to review my chart to determine if I am eligible to participate.

_____ _____

Patient Signature Date

Alaska Cancer Care Alliance

Date _____

AUTHORIZATION TO USE, DISCLOSE, AND EXCHANGE OF HEALTH INFORMATION THROUGH THE ALASKA CANCER CARE ALLIANCE

Patient Name _____ Date _____

I authorize the participants in the Alaska Cancer Care Alliance (collectively, "Alliance Participants") to use, and to disclose to, receive from, and/or exchange with other Alliance Participants, all the health information relating to the Patient. Alliance Participants include: Alaska Imaging Associates; Alaska Oncology and Hematology; Anchorage Radiation Therapy Center; Valley Radiation Therapy Center; and such other health care providers that are or become Alliance Participants and that are or will be listed on our website at akcca.net. The Alaska Cancer Care Alliance is a non-profit organization dedicated to easing some of the burden on cancer patients, including centralizing patient registration, sharing test results, and updating patient information for, with, and among Alliance Participants to encourage continuity of care for the Patient, to promote the timeliness and accuracy of information, and to reduce inefficiencies. The Alaska Cancer Care Alliance also may assist the Patient and the Patient's family and friends with locating affordable room and board arrangements when the Patient travels for treatment purposes as well as providing or arranging other similar support measures. Such information also may be used for certain administrative and operational functions of the Alliance. For the purpose(s) of accomplishing the Alliance's goals, as described above, I authorize all of the Patient's health information, including but not limited to, the information listed below, to be used, disclosed, received and/or exchanged:

- Health and Condition
- Seizures/Epilepsy
- Mental health
- Demographic
- Ulcer
- Diagnosis
- Kidney problems
- HIV / AIDS
- Treatment
- Hepatitis/Jaundice at birth
- Substance abuse
- Developmental disabilities
- Laboratory, radiology, and other test results

ACKNOWLEDGMENT:

1. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, payment for services from Alliance Participants, enrollment in a health plan, or eligibility for benefits.
2. I acknowledge and understand that I may revoke this authorization at any time by notifying, in writing, the privacy officer of any Alliance Participant, except to the extent that action already has been taken in reliance upon this authorization.
3. The Alliance is committed to protecting the confidentiality, privacy, and security of the Patient's health information. Generally, Alliance Participants either are health care providers that must comply with federal and state confidentiality, privacy, and security laws and ethical obligations or have signed agreements promising to safeguard the confidentiality, privacy, and security of Patient health information. We are, however, obligated by federal law to state in this authorization that the health information used, disclosed, received, and/or exchanged under this authorization potentially may be subject to redisclosure and no longer be protected by those laws.
4. I will receive a copy of this authorization after I sign it. I may inspect or request copies of information disclosed by this authorization.
5. Unless revoked, this authorization is limited to the following first and last dates:

COMMENCING: O Date of authorization O Other (specify): _____ ENDING (expiration date or expiration event): (90) days after the treatment relationship ends between the Patient and all Alliance Participants

SIGNATURE: I HAVE READ AND UNDERSTAND THIS AUTHORIZATION AND HAVE HAD AN OPPORTUNITY TO HAVE ANY QUESTIONS ANSWERED

_____ Date _____
Signature of Patient or Legally Authorized or Personal Representative

_____ Date _____
Grounds for Authority (If signed by Legally Authorized or Personal Representative)

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Date: _____
Name: _____

Medical History

What is your reason for visit today? _____

Where and when were you diagnosed? _____

Please select services you need help with below:

Housing in Anchorage ❑Yes ❑No Finances ❑Yes ❑No Care at home ❑Yes ❑No

Medical equipment ❑Yes ❑No Transportation ❑Yes ❑No Emotional support ❑Yes ❑No

Other (please explain) _____

_____

How would you describe your past health? ❑Well ❑Often Ill ❑Always Ill

Primary care physician Name _____ Phone _____

List previous physicians you have seen, please include first name, city, state and phone:

Physician	City/State	Phone

Please list allergies

Food/Drug	Reaction

Please list name of preferred pharmacy and location _____

Please list current medications:

Medication Name	Dosage	Reason used

Please list any previous cancer treatments please include dates, radiation therapy, chemotherapy, and surgery

_____

_____

_____

_____

_____

Vaccines	**Yes**	**No**
Influenza vaccine	❑	❑
Pneumococcal vaccine	❑	❑

If no, reason _____

Dates _____

Tobacco use:	❑	❑
Current every day	❑	❑
Current someday	❑	❑
Never	❑	❑

If former How long? _____ # packs per day ____

Date you quit _____

If you currently smoke, would you like cessation counseling? ❑Yes ❑No

Alcohol use:	❑	❑

If yes, amount and type? _____

Recreational drug use	❑	❑

Family and social history	**Yes**	**No**

Mother Living age ___ Deceased

age and cause of death _____

Maternal grandmother Living age _____

Deceased	❑	❑

Age and cause of death _____

Maternal grandfather Living age _____

Deceased	❑	❑

Age and cause of death _____

Father Living age ____ Deceased	❑	❑

Age and cause of death _____

Paternal grandmother Living age _____

Deceased	❑	❑

Age and cause of death _____

Paternal grandfather Living age _____

Deceased	❑	❑
Children Living	❑	❑

Age's _____

Siblings Living	❑	❑

Age's _____

Environmental	**Yes**	**No**
Any domestic concerns?	❑	❑
Is anyone harming you?	❑	❑
Emotional support?	❑	❑
Are you coping?	❑	❑
Social services referral?	❑	❑

Living situation	**Yes**	**No**
Independent	❑	❑
Living with family care	❑	❑
Home health care	❑	❑
Rehab facility	❑	❑
Nursing home	❑	❑
Assisted living facility	❑	❑

Past Medical History

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Surgical History. Include date, type and facility.

_____

_____

_____

_____

_____

_____

_____

Review of systems	**Yes**	**No**
General problems		
Fatigue	❑	❑

Mild, moderate, severe?_____

Fevers	❑	❑
Chills	❑	❑
Sweats	❑	❑
Hot flashes	❑	❑
More than one hot flashes a day?	❑	❑
Ocular/Vision		
Vision problems	❑	❑
Blurred vision	❑	❑
Recent change in vision	❑	❑
Eye pain	❑	❑

Respiratory	**Yes**	**No**
Respiratory problems	❑	❑
Have you been out of the country in the last three months?	❑	❑
Where? _____		
Any respiratory illnesses?	❑	❑
Exposed to respiratory illness?	❑	❑
Wheezing	❑	❑
Cough	❑	❑
Shortness of breath	❑	❑

Ears/ Nose / Throat	**Yes**	**No**
ENT problems	❑	❑
Change in hearing	❑	❑
Ringing in ears	❑	❑
Nose bleeds	❑	❑
Sinus problems	❑	❑
Gums bleeding /sores	❑	❑
Sore throat / hoarseness	❑	❑

Cardiovascular	**Yes**	**No**
Chest pain	❑	❑
Palpitations	❑	❑
Swelling of extremities	❑	❑
Fainting	❑	❑
Blood clots	❑	❑
Nutritional screening		
Current diet: _____		
Poor appetite	❑	❑
swallowing problems	❑	❑
Unplanned weight loss	❑	❑
If yes, how many lbs _____		

Gastrointestinal	**Yes**	**No**
Change in appetite	❑	❑
Heartburn	❑	❑
Abdominal pain-Cramping	❑	❑
Nausea	❑	❑
Vomiting	❑	❑
Diarrhea	❑	❑
Constipation	❑	❑
Black- bloody stools	❑	❑
Rectal bleeding	❑	❑
Hemorrhoids	❑	❑
When was your last colonoscopy? _____		

Urinary	**Yes**	**No**
Blood in urine	❑	❑
Painful urination	❑	❑
Difficulty starting stream	❑	❑
Scrotal mass	❑	❑
yes, how long have you noticed it? _____		

Reproduction (women only)

Age at menarche _____
Last menstrual period _____
Age at Menopause _____
Number of pregnancies _____
Number of live births _____
Number breast fed _____

	Yes	**No**
Were you ever on birth control pills?	❑	❑
If yes, how many years?____ Date stopped? _____		
Were you ever on Hormonal replacement therapy?	❑	❑
How many years? _____		
When was your last mammogram? _____		
Last pap smear? _____		
Breast tenderness	❑	❑
Breast masses	❑	❑

Skin	**Yes**	**No**
Rashes	❑	❑
Change in mole	❑	❑
Non healing wound	❑	❑
Itching	❑	❑
Hair loss	❑	❑
Change in nails	❑	❑

Functional	**Yes**	**No**
Difficulty with sight	❑	❑
Difficulty with hearing	❑	❑
Hearing aids	❑	❑
Glasses	❑	❑
Contacts	❑	❑
Mobility assistance	❑	❑
Device needed? ❑Wheel chair ❑Cane or ❑Walker		
Joint swelling or tenderness	❑	❑
Muscle pain	❑	❑
Back pain	❑	❑
Falls	❑	❑

Neurological	**Yes**	**No**
Headaches/ Migraines	❑	❑
Dizziness	❑	❑
Numbness/ Tingling	❑	❑
Seizures	❑	❑
Weakness	❑	❑
Paralysis	❑	❑
Change in gait or balance	❑	❑
Tremors	❑	❑
Heat/ cold Intolerance	❑	❑

Psychiatric/Emotional	**Yes**	**No**
Change in memory	❑	❑
Change in mood	❑	❑
Depression	❑	❑
Anxiety	❑	❑

Bleeding or swelling	**Yes**	**No**
Easy bruising	❑	❑
Frequent bleeding	❑	❑
Swollen glands	❑	❑
Are you taking anticoagulants?	❑	❑

Pain Assessment	**Yes**	**No**
Pain	❑	❑

Where is the pain located?_____

_____

_____

Can you describe the pain?_____

_____

_____

How long does the pain last? _____

_____

Is it constant ❑ ❑

What methods do you use to relieve the pain? _____

_____

_____

If you take medication for the pain, what do you take?

_____

_____

_____

_____