alaska oncology
AND HEMATOLOGY, LLC

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

Today's 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: _____ May we leave a message on your voicemail? ○ **Yes** ○ **No**

Employer: _____ Occupation: _____

Referring Physician: _____

Does your insurance have a hospital preference? _____ Pharmacy? _____ Lab: _____

Parent/Legal Guardian (if not patient): _____

Marital Status: ○ Married ○ Single ○ Widowed ○ Divorced **Gender:** ○ Male ○ Female

If married, spouse's name: _____ May we contact? ○ **Yes** ○ **No** Spouse's Phone: _____

Emergency Contact(s):

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Patient Portal Email Address: _____ Decline: ○ Are you a Veteran? ○ **Yes** ○ **No**

Insurance Information

Primary Insurance

Medicare Part A ○ **Yes** ○ **No**
Part B ○ **Yes** ○ **No**
Part D ○ **Yes** ○ **No**

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: _____

Signature: _____

Date: _____

Prescription Information:

Insurance _____

Prescription ID _____

Group # _____

BIN# _____

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FINANCIAL POLICY

PATIENT NAME:_____ **DATE OF BIRTH:**_____

Thank you for choosing us as your health care provider. 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. Please read and sign in the space provided.

All patients must complete our patient registration forms and give us the necessary information before seeing a provider.

INSURANCE: Our practice **is contracted with the following insurance plans: Aetna, Blue Cross Blue Shield, ChampVA, Medicare, Medicaid, Multiplan/Beechstreet/PHCS, Public Education Health Trust Group 350, VA, Tricare and UnitedHealthcare.** If we are contracted with your insurance plan you will be responsible for your Copay, Deductible, Coinsurance, non-covered or denied services as indicated by your insurance plan.

If your insurance is not listed above or you are unsure of your benefits we advise you to contact your insurance carrier.

If we are **not contracted** with your insurance plan we will submit claims on your behalf and will process payments by your insurance company. Please be aware that you are responsible for payment regardless of the insurance company's determination of usual and customary rates for services; also known as the allowed amount. Any unpaid balance will be your responsibility.

Your insurance coverage is a contract between you and your insurance plan. Your insurance plan is accountable to you. Do not hesitate to contact them if you disagree with their payment. Should you need additional assistance we are available and will do our best to answer your questions.

IF YOUR INSURANCE CHANGES it is important you notify our office immediately to prevent delays in treatment, additional cost to you and to keep our records accurate.

SELF PAY-NO INSURANCE: If you do not have Insurance coverage you will be expected to pay at the time of service unless prior arrangements have been made with your Billing Account Representative.

We accept the follow forms of payment: Cash, Check, Visa, MasterCard, Amex and Discover
Returned checks are subject to additional collection fees.

If you do not show up for your appointment or do not cancel 24 hours in advanced you may be charged a fee for your No Show or Missed appointment.

If you have any questions regarding this Financial Policy, please ask or call 907-279-3155 to speak with one of our Billing Account Representatives.

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 authorized my Insurance company(s) to pay benefits directly to Alaska Oncology and Hematology, LLC if not paid in full at 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/paid by my insurance.

_____ _____

Signature of Patient or Responsible Party Date

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Max Rabinowitz, M.D.
Steven Liu, M.D.

Zach Zipsir, PA-C
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YOUR RIGHT TO PRIVACY

Patient Name: _____ Date of Birth: _____

If you would like our office 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 AND APPOINTMENTS.

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 requests and to download prescription history as necessary.

☐ **YES** ☐ **NO**

ACKNOWLEDGMENT OF 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: _____

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Name: _____

Date: _____

Medical History

What is your reason for a 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

Allergies:

Food/Drug/Misc.	Reaction

Preferred Pharmacy and Location: _____

Please list current medication: (If you have a list we can make a copy)

Medication Name	Dosage and Frequency of Use	Reason Used

Vaccines	*Yes*	*No*
Influenza vaccine	☐	☐
Pneumococcal vaccine	☐	☐
Covid vaccine	☐	☐

Other _____
Date of vaccination _____
If no, reason _____

Tobacco Use
Never ☐
Current every day ☐
Current some days ☐
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 & 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	☐	☐
Age and cause of death _____		
Children living	☐	☐
Ages _____		
Siblings living	☐	☐
Ages _____		

Environmental/Social	*Yes*	*No*
Any domestic concerns?	☐	☐
If yes, please list _____		
Emotional support available	☐	☐
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
☐ **None**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Surgical History **(include date, type and facility)**
☐ **None**

_____
_____
_____
_____
_____
_____

Review of Symptoms

General Problems	*Yes*	*No*
Fatigue	☐	☐
Mild, Moderate, Severe _____		
Fevers	☐	☐
Chills	☐	☐
Sweats	☐	☐
Hot flashes	☐	☐
More than one hot flash a day	☐	☐

Ocular/Visual

Blurred vision	☐	☐
Recent change in vision	☐	☐
Eye pain	☐	☐

Other (specify) _____

Respiratory	*Yes*	*No*
Traveled out of the country in the last three months	☐	☐
If yes, where? _____		
Any respiratory illnesses?	☐	☐
Wheezing	☐	☐
Coughing	☐	☐
Shortness of breath	☐	☐

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

Cardiovascular	*Yes*	*No*
Chest pain	☐	☐
Palpitations	☐	☐
Swelling of extremities	☐	☐
Fainting	☐	☐
Blood clots	☐	☐

Nutritional Screening	*Yes*	*No*
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	☐	☐
Hemorrhoids	☐	☐
Date of last Colonoscopy _____		

Urinary	*Yes*	*No*
Blood in urine	☐	☐
Painful urination	☐	☐
Difficulty starting stream	☐	☐
Scrotal mass	☐	☐

If yes, how long have you noticed it? _____

Reproduction (women only)

Age at menarche (initial period) _____
Last menstrual period _____
Age at menopause _____
Number of pregnancies _____
Number of live births _____
Number breast fed _____

Were you ever on birth control pills	*Yes*	*No*
	☐	☐

If yes, how many years _____ Age ended__

Were you ever on Hormonal Replacement Therapy?		
	☐	☐

If yes,how many years? _____
Date of last Mammogram _____
Date of last PAP Smear _____

Skin	*Yes*	*No*
Rashes	☐	☐
Change in mole	☐	☐
Non-healing wound	☐	☐
Itching	☐	☐
Hair loss	☐	☐
Change in nails	☐	☐
Breast tenderness / masses	☐	☐

Functional / Musculoskeletal	*Yes*	*No*
Difficulty with sight	☐	☐
Difficulty with hearing	☐	☐
Hearing aids	☐	☐
Glasses	☐	☐
Contacts	☐	☐
Mobility assistance	☐	☐
Device needed ☐ Wheel chair ☐ Cain ☐ 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	☐	☐
Are you taking anticoagulants?	☐	☐

Pain Assessment	*Yes*	*No*
Do you have pain now?	☐	☐

Pain intensity 1 2 3 4 5 6 7 8 9 10

(1 being mild, 10unbearable)

Where is pain located? _____

_____

Pain level acceptable ☐ ☐

Pain description/quality (ache/cramping/sharp)

_____

_____

Pain duration (brief/constant/intermittent)

_____

What methods do you use to relieve the pain?

_____

_____

_____

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

_____

_____

_____