INTERNAL MEDICINE ASSOCIATES, LLC
NEW PATIENT INFORMATION

Appointment Date & Time:

PATIENT INFORMATION			
Last Name:	First Name:	Middle Initial:	Marital Status:
Social Security #:	Date of Birth:		Gender
Address:		Home Phone:	
City, State, Zip:		Cell Phone:	
Employer:		Work Phone:	
Employer Address:		Employment Status:	
City, State Zip:		E-Mail:	

REFERRING INFORMATION
IMA Physician:
Were you referred by a physician? Yes No Referring Physician:

INSURANCE INFORMATION	
Primary Insurance:	Policy/Subscriber
Address:	Insured Policy ID:
City, State, Zip:	Group Number:
Plan Phone:	Date of Birth:
Effective Dates:	Patient Relationship to Subscriber:
Second Insurance:	Policy Subscriber:
Address:	Insured Policy ID:
City, State, Zip:	Group Number:
Plan Phone:	Date of Birth:
Effective Dates:	Patient Relationship to Subscriber:

EMERGENCY CONTACT OR PARENT/LEGAL GUARDIAN INFORMATION	
Parent/Legal Guardian Name:	**Emergency Contact:**
Address(if different than patient):	Address(if different than patient): Patient relationship to Contact:
Parent Home Phone:	Contact Home Phone:
Parent Work Phone:	Contact Work Phone:

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

I hereby authorize Internal Medicine Associates to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges., I hereby authorize Internal Medicine Associates to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by me.

X_____ Date:_____
Signature

Employee Initials (initial after data entry): _____

Internal Medicine Associates, LLC
2841 DeBarr Road, Suite 50 * Anchorage, AK 99508
(907) 276-2811 * (888) 935-2811 Toll Free * (907) 276-2810 Fax

- I authorize Internal Medicine Associates, LLC to bill my insurance and release medical or other information necessary to process my medical claims. I request payment of government benefits either to myself or to the party that accepts assignment.

  _____ Refusal Initial

- I acknowledge and agree to all financial responsibilities outlined at the bottom of this agreement*.

  _____ Refusal Initial

- I acknowledge and agree that I have been offered a copy of Internal Medicine Associates, LLC's Notice of Privacy Practices.

- I acknowledge I could be charged a $50 fee if I do not show for an appointment and/or procedure, or if I fail to cancel or reschedule without 24 hour notice.

- **Medicare Patients Only** – I request that payment under the medical insurance program be made either to me or to Internal Medicine Associates, LLC for services furnished to me. I authorize Internal Medicine Associates, LLC to release to the Social Security Administration, or its intermediaries or carriers any information needed to process this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

  _____ Refusal Initial

Patient Signature	Date
Patient Legal Representative (if applicable)	Date
Print Name of Legal Representative	Relationship to patient

"All new patients are required to complete all necessary forms as determined by Internal Medicine Associates, LLC. No physician-patient relationship shall be created until all forms are completed and the physician personally evaluates the patient. Refusal to complete all forms is a basis for the physicians to refuse to evaluate or treat a prospective patient."

*Patient's Financial Responsibility

- **Payment of your deductible**, if not already met, and the patient's portion of your charges are required ***at the time of service***. Payment can be made by cash, check, or credit card.
- If you need to make other financial arrangements, please ask to see an account representative.
- Internal Medicine Associates, LLC bills your insurance as a courtesy. However, there are many insurance plans in the United States and it is impossible for IMA to know the specific benefits to your plan. **It is your responsibility, not your insurance companies, to make sure your bill is paid.**
- If you want us to bill your insurance, you must provide us with:
  - An assignment of benefits (at the top of this form)
  - A signed claim form and a copy of your insurance card
- Your insurance company may pay on charges according to their usual and customary fee scale. Internal Medicine Associates, LLC's fees are set independently from the insurance company guidelines. In the event your insurance company determines a service to be "not covered" or "above the usual or customary charges", you will be responsible for the balance due.
- **It is the patient's responsibility to preauthorize with their insurance company prior to any procedure or testing.**
- In many instances, your physician may order services or testing which are independent from IMA. Such organizations include laboratories, pathologists, x-ray facilities, and hospitals. These organizations and physicians will directly bill you and your insurance for their services. Our office may provide them with billing information.
- It is the patient's responsibility to call at least 24 hours prior to their appointment or procedure to cancel/reschedule. Failure to do so or failure to show for the appointment/procedure could result in a $50 no-show/late cancellation fee.

Internal Medicine Associates, LLC

Health and History

Date: Patient Name: DOB: Gender: ___Age: ___

Occupation: _____ Marital Status: _____

Referring M.D.: _____ Primary Care Provider: _____

Chief Complaint/Reason for Visit: _____

Medications/Vitamins (Prescription and/or over the counter)

Name:	Size (mg):	Times/day:	Prescribed by:

Allergy/Reaction

Drug name	Reaction

Surgery	**Year**

Hospitalization	**Year**

Social History

Do you currently use tobacco? ___ Yes ___ No Have you ever used tobacco? ___ Yes ___ No

per day: ___ Cigarettes ___ Cigars ___ Chewing What years have you used tobacco products? _____

Do you drink alcohol? ___ Yes ___ No # per week of: ___ Beer ___ Wine ___ Liquor

Do you drink caffeine? ___ Yes ___ No # per day of: ___ Coffee ___ Tea ___ Cola

Recreational or I.V. Drug use? Yes No What kind/number of pets?

Family History

__ Heart disease – Relative: _____
__ Hypertension – Relative: _____
__ Emphysema – Relative: _____
__ Colon polyps – Relative: _____
__ Gallbladder disease – Relative: _____
__ Diabetes – Relative: _____
__ Sleep apnea – Relative: _____

___ Cancer – Relative: _____
___ Asthma – Relative: _____
___ Colitis – Relative: _____
___ Colon cancer – Relative: _____
___ Hepatitis – Relative: _____
___ Depression – Relative: _____
___ Other – Relative: _____

Relative:	Age:	Illness:	Deceased:	
Father	_____	_____	___ Yes	___ No
Mother	_____	_____	___ Yes	___ No
Brother	_____	_____	___ Yes	___ No
Sister	_____	_____	___ Yes	___ No
Child	_____	_____	___ Yes	___ No
Grandmother	_____	_____	___ Yes	___ No
Grandfather	_____	_____	___ Yes	___ No

TURN OVER AND COMPLETE OTHER SIDE

Patient Name: DOB

Past Medical History & Review of Systems – check all that apply

Systemic

Review of Systems:

___ Fatigue
___ Fever
___ Chills
___ Change in weight
___ Night sweats

EENT

Past Medical History:

___ Glaucoma
___ Hearing loss

Review of Systems:

___ Headache
___ Sinus pressure
___ Neck pain/stiffness
___ Neck swelling/lump
___ Vision problems
___ Eye itching/pain
___ Ear ache
___ Nasal discharge/blockage
___ Hoarseness
___ Sore throat
___ Bleeding gums
___ Mouth sores

Cardiovascular

Past Medical History:

___ High blood pressure
___ High cholesterol
___ Heart attack
___ Heart murmur
___ Prolapsing Mitral Valve
___ CAD
___ On blood thinners
___ Blood clots
___ Angina

Review of Systems:

___ Chest pain
___ Palpitations

Pulmonary

Past Medical History:

___ Asthma
___ Bronchitis
___ History of TB
___ Use of BCG vaccine
___ Emphysema
___ COPD
___ Apnea
___ Abnormal chest X-ray/chest CT
Date/Location:_____

Pulmonary - continued

Review of Systems:

___ Cough
___ Wheezing
___ Shortness of breath
___ Snoring
___ Excessive daytime sleepiness
___ Chest pain w/ deep breathing
___ Chest pain w/ rotating torso

Gastrointestinal

Past Medical History:

___ Crohn's Disease
___ Ulcerative Colitis
___ Esophageal Reflux
___ Hepatitis
___ Gallbladder Disease/Gallstones
___ Colon cancer
___ Intestinal Polyps removed
Date: _____

Review of Systems:

___ Appetite changes
___ Difficulty swallowing
___ Heartburn
___ Nausea
___ Vomiting
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Change in bowel habits
___ Bloody or black stools
___ Uncontrollable gas/bloating

Genitourinary

Past Medical History:

___ Urinary tract infection (UTI)
___ Kidney stones
___ Are you pregnant?
Date of last period: _____

Review of Systems:

___ Blood in urine
___ Burning during urination
___ Increased urinary frequency

Musculoskeletal/Rheumatology

Review of Systems:

___ Joint pain/stiffness
___ Joint swelling
___ Back pain
___ Muscle aches or weakness
___ Scleroderma
___ Other: _____

Neurological

Review of Systems:

___ Dizziness
___ Fainting
___ Numbness
___ Sensory disturbances
___ Stroke
___ Seizure disorder

Endocrine

Past Medical History:

___ Thyroid disease
___ Thyroid cancer
___ Adrenal tumor
___ Pituitary tumor
___ Parathyroid disease
___ Osteoporosis
___ Diabetes
___ Gestational diabetes

Review of Systems:

___ Heat or cold intolerance
___ Excessive thirst or urination
___ Excessive sweating
___ Change in libido (sex drive)
___ Change in shoe or ring size
___ Stretch marks
___ Facial hair growth (women)

Psychological

Past Medical History:

___ Anxiety
___ Depression

Review of Systems:

___ Sleep disturbances
___ Confusion
___ Memory lapse or loss
___ Other: _____

Skin

Past Medical History:

___ Eczema
___ Psoriasis

Review of Systems:

___ Itching
___ Skin lesions
___ Rashes

Hematologic

Past Medical History:

___ Anemia
___ Easy bleeding

Other

___ HIV-1 infection

Patient Signature: _____ Physician Signature: _____ Date: _____

INTERNAL MEDICINE ASSOCIATES, LLC
2841 DEBARR RD SUITE 50
ANCHORAGE, AK 99508
Phone (907) 276-2811 Fax (907) 276-2810

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION
(REQUEST FOR RELEASE OF MEDICAL RECORDS)

I, _____ date of birth _____, authorize Internal Medicine Associates, LLC. to use and/or disclose my health information to: **Myself** and/or _____.

I authorize disclosure of the following types of health information

Types of Health Information *If not checked, default is ALL TYPES*	**Date(s) of Service for requested records** *If left blank, default is ALL DATES*	**For the following purpose(s)** *If not checked, default is CONTINUATION OF CARE*
☐ Office/ Provider Notes	_____	
☐ Laboratory Reports	_____	☐ Continuation of Care
☐ Pathology and Biopsy Reports	_____	☐ Personal Request
☐ Imaging Studies	_____	☐ Insurance Claims
☐ Billing Statements	_____	☐ Legal Request
☐ Other: _____	_____	☐ Other:_____

* The following items must be initialed to be included in the use or disclosure of other health information:

_____ *HIV/HCV/AIDS / SEXUALLY TRANSMITTED related health information and/or records

_____ *Mental health information and/or records

_____ *Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information): _____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to **the Practice Manager or the Privacy Officer**. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand I have a right to obtain a copy of this Authorization, upon requesting. **I understand that this form does not supersede any previously signed Release of Information.**

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

_____ _____
Signature of Individual or Individual's Legal Representative | Date Signed (Expires one year after signature)

_____ _____
Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Individual

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