GRANT SEARLES, M.D. **Phone:** 907-277-1197 **Fax:** 907-277-1139
1200 Airport Heights Dr. Suite 350 Anchorage, AK 99508

PATIENT INFORMATION

Name: _____ **Gender:** ○Male ○Female

Date of Birth: _____ **Age:** _____ **Social Security #:** _____-_____-_____

Physical Address: _____

Mailing Address: _____

Employment Type: ☐Full-time ☐Part-time ☐Student (full-time) ☐Student (part-time) ☐Retired ☐Unemployed ☐Disabled ☐Homemaker ☐Self-employed

Occupation & Employer: _____

Home Phone: _____ ☐Leave detailed information ☐Leave only a callback number

Work Phone: _____ ☐Leave detailed information ☐Leave only a callback number

Cell Phone: _____ ☐Leave detailed information ☐Leave only a callback number ☐OK to text

Email Address: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow(er) **Spouse Name:** _____

Spouse Date of Birth: _____ **Spouse Social Security #:** _____-_____-_____

Spouse Phone: _____ **Spouse Employment Type:** ☐Fulltime ☐Part time ☐Unemployed ☐Retired

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

Policy ID/Member #: _____ **Group #:** _____

Subscribers Relationship to Patient: ☐Self (If self, skip to secondary insurance information) ☐Spouse ☐Parent

Subscriber Name: _____ **Subscribers Phone:** _____

Subscribers Date of Birth: _____ **Subscriber Social Security #:** _____-_____-_____

SECONDARY INSURANCE: _____

Policy ID/Member #: _____ **Group #:** _____

Subscribers Relationship to Patient: ☐Self (If self, skip to Patient Care Team Information) ☐Spouse ☐Parent

Subscriber Name: _____ **Subscribers Phone:** _____

Subscribers Date of Birth: _____ **Subscriber Social Security #:** _____-_____-_____

PATIENT CARE TEAM INFORMATION

Referring Physician: _____

Primary Care Physician: _____

Other Physicians on your care team: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____

Phone: _____ **Relationship to Patient:** _____

By signing below, I authorize this office to release any information necessary to expedite payment. Protected health information may be disclosed to another covered entity for select health care operation such as payment activities, treatment, quality assessment activities, and other purposes. I have signed a copy of the Office Policy and been offered a copy of the Notice of Privacy Practices. I understand the organized health care arrangement has the right to change this notice at any time and that I may obtain a current copy by contacting the office. Regardless of insurance coverage I also understand that I am ultimately responsible for all charges, including attorney's fees and collection costs.

_____ _____

Signature of Patient Date

GRANT SEARLES, M.D., FACS
1200 Airport Heights Dr., Suite 350 Anchorage, AK 99508

Office Policy

Appointments and Patient Noncompliance

We recognize that your time is valuable, and we will make every effort to maintain the scheduled appointment times. You will be asked to come to the office at least 15 minutes early to allow time for updates to your contact information. However urgent situations sometimes disrupt our schedule, and we ask for your understanding and patience during these delays. We will make every effort to keep your wait time to a minimum.

If you are unable to keep your appointment, please call. Late arrival may necessitate rescheduling your appointment. Cancellations should be made as early as possible, and we must be notified no later than 24 hours beforehand. If a patient does not call within 24 hours to cancel or fails to keep a second appointment a $50.00 charge will be applied. Failure to show up for an appointment where no cancelation notice was given will be noted in your chart as a "No Show". Additionally, if three such events occur, we may ask you to find a new provider.

We are here to provide the highest standard of medical care. As such we reserve the right to terminate our healthcare relationship with you. You would be notified in writing via certified mail. We will continue to provide emergency/urgent care for 15 days, after 15 days we will no longer provide any medical services.

Emergencies and After-Hours Calls

When the office is closed and it's a **medical emergency** you should **call 911.** You can reach our answering service by calling our office and pressing option **2** regardless of the hour. The answering service will ask your name, telephone number, and the reason for your call. This information will be relayed to the doctor on call regardless of the hour. For routine questions and refill requests, we ask that you please call the office on the next business day or leave a message on the phone.

Insurance Coverage and Our Financial Policy

You will be asked to provide your insurance card(s) at every visit. This is to ensure that the information we have is correct, and that your plan is current and one in which we participate. Out of date cards with incorrect information or the wrong insurance cards can cause unnecessary delays in the payment of your claim.

Frequently, small changes (for example, a group number change or plan change) may not be considered significant by patients, but insurers will not process claims that are not 100% accurate.

All office co-pays are to be paid at the time of service. If the co-pay cannot be made at the time of service, your appointment will be rescheduled to a later date when you have the funds available to accommodate your co-pay. **This is also an insurance company policy.** We accept checks, credit cards, or cash.

We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for medical care is a contract between **you** and the **carrier**. You should direct any questions and/or complaints regarding coverage to your insurance carrier, your employer (if in a group plan), or to your agent.

Insurances vary in their coverage, and it is the **patient's responsibility** to understand his/her medical benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company. Patients are responsible for any co-insurance, deductibles, and any other non-covered billable services. We are **only** contracted with Blue Cross, Tricare, VA, Medicare, and Medicaid. We are only a preferred provider with Blue Cross.

Payments

Balances are due within 30 days of when the bill is issued. Bills will be issued after the insurance carrier pays its portion of the bill. We accept checks, cash, and credit cards. In addition to paying through the mail, credit card information may also be called to the billing office during business hours at 770-2380. Any patient whose personal check comes back with insufficient funds will be charged a fee of $40 in addition to the original bill.

By signing below, I have reviewed the office policies listed above. I understand the organized health care arrangement has the right to change this notice at any time and that I may obtain a current copy by contacting the office. Regardless of insurance coverage I also understand that I am ultimately responsible for all charges, including attorney's fees and collection costs.

_____ _____

Signature of Patient **Date**

Patient Health History Form

Date:_____

Name: _____DOB: _____

Past Medical History: Please check all that apply to you:

- ☐ Arthritis
- ☐ Acid Reflux disease (heart burn)
- ☐ Depression
- ☐ Diabetes
- ☐ Bleeding/Tendency to Bleed
- ☐ Heart problems
- ☐ Gallbladder Disease
- ☐ High blood pressure
- ☐ Hepatitis _____
- ☐ Intestinal Disease
- ☐ Thyroid Disease
- ☐ Liver Disease
- ☐ Sleep Apnea
- ☐ Sleep Distrubance
- ☐ Other _____

_____

_____

Surgical History: Please list your past surgeries in chronological (time) order:

Date	Type of operation	Reason for surgery	Hospital	Doctor

Radiation History: Please list any radiation therapy/treatment you've had in chronological (time) order:

Date started	Date stopped	Area of body treated	Hospital	Doctor

Other Hospitalizations: Please list any other hospitalizations in chronological (time) order

Date admitted	Reason for hospitalization	Outcome/diagnosis	Hospital	Doctor

Medications: Current prescription and over the counter medications/supplements/herbal remedies

Medication	Dosage	Frequency	Date started	Reason
Eg: Tylenol	*200mg*	*2x daily*	*01/01/2001*	*Pain*

Do you drink alcohol? ☐Yes ☐No If yes, how much/week? _____

Do you smoke? ☐Yes ☐No If yes, how many cigarettes/day? _____

Have you smoked in the past 10 years? ☐Yes ☐No If yes, how long?_____

Do you use recreation drugs? ☐Yes ☐No If yes, what type and frequency? _____

Do you consume caffeine? ☐Yes ☐No how many cups/week? _____

Patient Health History Form **Date:**_____

Name: _____DOB: _____

Family History: Do you know of any blood relative who has or had:

- ☐ Asthma/Hay Fever/ Other Allergies
- ☐ Anemia
- ☐ Bleeding Disorder: _____
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Chronic Arthritis
- ☐ Emphysema
- ☐ Nervous Disorder: _____
- ☐ Cancer:_____
- ☐ Mental Disorder: _____
- ☐ Other Family Disease: _____

Review of Sypmtoms: As you review the following list, please check any problems or conditions that you are currently experiencing or have experienced in the recent past

General Health

- ☐ Recent weight change
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Rheumatic Fever
- ☐ Abnormal Bleeding
- ☐ Bleeding Disorer:_____
- ☐ Easy Bruising
- ☐ Blood Clots/DVT
- ☐ Lump(s) in Breast(s)
- ☐ Pain in Breast
- ☐ Nipple Discharge
- ☐ Diagnosed with HIV/AIDS _____
- ☐ Diagnosed with Hepatitis _____

Ears, Nose, Throat

- ☐ Earaches
- ☐ Decrease in Hearing
- ☐ Loss of hearing/deafness
- ☐ Ringing/Buzzing in ears
- ☐ Persistent Nose Bleeding
- ☐ Sinus Trouble
- ☐ Difficulty swallowing
- ☐ Hoarsness/Voice Changes
- ☐ Sore Throat
- ☐ Thyroid Trouble or Goiter
- ☐ Thyroid Medications or Tests
- ☐ Sputum Production
- ☐ Other: _____

Eyes

- ☐ Glasses/Contacts
- ☐ Cataracts
- ☐ Other: _____

Gastrointestinal

- ☐ Acid Reflux Disease (Heart Burn)
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach/Liver/Intestinal Issues
- ☐ Persistent Diarrhea
- ☐ Constipation
- ☐ Blood in stools
- ☐ Hemorrhoids
- ☐ Abdominal Pain
- ☐ Other: _____

Genitourinary

- ☐ Female: Period Onset Age_____
- ☐ Female: #pregnancies_____
  #miscarriages_____
  #abortions_____
  #births_____
- ☐ Female: Last Period Date_____
- ☐ Female: Period Length _____
- ☐ Female: Periods Interval _____
- ☐ Female: Menopause Age _____
- ☐ Female: Irregular Periods
- ☐ Female: Vaginal Discharge
- ☐ Female: Vaginal Bleeding After Intercourse
- ☐ Female: Excessively Painful Periods
- ☐ Male: testicle pain R L
- ☐ Male: prostate disease
- ☐ Frequent Urination
- ☐ Passing Urine at Night
- ☐ Painful or burning urination
- ☐ Sexual difficulty
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Recent Urinary Tract Infection
- ☐ Other: _____

Heart

- ☐ Pain in chest
- ☐ High blood pressure
- ☐ Pressure in the Chest
- ☐ Irregular heart beat
- ☐ Heart Disease
- ☐ Congestive Heart Failure
- ☐ Other: _____

Neurological

- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Sensations of Spinning
- ☐ Headaches/Migraines
- ☐ Unusual Forgetfulness
- ☐ Other: _____

Sleep

- ☐ Sleep Apnea
- ☐ Snoring

Do you sleep well? ☐Yes ☐No

Do you feel rested when you wake? ☐Yes ☐No

Do you fall asleep during the day? ☐Yes ☐No

Pulmonary

- ☐ Asthma
- ☐ Coughing Up Blood
- ☐ Chronic or Frequent Cough
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Tuberculosis (TB)/Possitive TB Test
- ☐ Pulmonary Embolisim (Blood Clot in Lungs)

Muscles/Joints/Bones

- ☐ Back Pain
- ☐ Bone Pain
- ☐ Muscle Weakness
- ☐ Muscle Pain/Tenderness
- ☐ Difficulty walking
- ☐ Arthritis

Skin

- ☐ Rash
- ☐ Itching
- ☐ Other: _____

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Other: _____

Females Only:

- ☐ Taken Hormones

What Hormone _____
Dosage_____
When _____
How Long Were you on it_____

Allergies

List any medications, food, and/or latex products and your reaction to them:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____