Alaska Pediatric Surgery LLC
J. Brent Roaten MD PhD / Carolyn M. Van de Rostyne ANP
4100 Lake Otis Pkwy Suite 206 Anchorage Alaska 99508
907.929.7337 ph 907.929.7330 fx

New Patient Intake

Date_____________**PATIENT NAME:**_______________________**DATE OF BIRTH:**__________________**Male** ___**Female** ___

Form completed by: ___________________________________ Relation to Patient ___________________________________

Reason for Visit: ____

Grade: ____________________________ **Home Town** ____

Pets:____ **Exposure to smoke or tobacco products:** ___________________

Please tell us about your child's history:

MEDICAL Problems: ____

PAST SURGERIES: ____

Other HOSPITALIZATIONS (not for surgery)____

ALLERGIES:____

MEDICATIONS and Dosing ____

____ ____

____ ____

____ ____

____

FAMILY HISTORY Medical/Surgical Conditions

Mother: Y / N Bleeding disorder Y / N Anesthesia issues. Other:____

Father: Y / N Bleeding disorder Y / N Anesthesia issues. Other:____

Siblings: **:** Y / N Bleeding disorder Y / N Anesthesia issues. Other:____

Grandparents/Aunt/Uncles: Y / N Bleeding disorder Y / N Anesthesia issues.Other: ____________________________

Does your child have any of the following problems or issues

GENERAL __ fever. ___ Changes in Activity or Appetite __irritability, fatigue, or unexpected weight change ________

HEENT: __eye, ear pain or discharge __mouth sores ___no loose teeth __sinus drainage _________________________

CVS/CHEST/RESP: __heart problems __ heart murmur __ cough __ breathing issues ______________________________

GI: __ nausea, vomiting __ abdominal pain __bowel movement every day?____

GU: __ pain or burning on urination __________________**SKIN:** __ rashes or lesions _______________________________

MS: __joint swelling or pain. __ Back issues:_________________________________

BRAIN: __ seizures ___ dizziness __________________________________ **BLEEDING:** __ easy bruising or bleeding

PSYCH/BEHAVIORAL: __ behavioral or psychological issues ____

OTHER:____

PATIENT

REGISTRATION

FORM

Alaska Pediatric Surgery, LLC

4100 Lake Otis Pkwy, Suite 206 • Anchorage, AK 99508
ph 907.929.7337 • f 907-929-7330

PATIENT INFORMATION:

LAST NAME: _________________________ FIRST NAME: ________________________ M.I. _____ SEX: ☐ M ☐ F

Date of Birth _________________ Social Security Number _______________________

REFERRING PROVIDER: ________________________________ CLINIC: ____________________________________

REGULAR PEDIATRICIAN: ______________________________ CLINIC: ____________________________________

PARENT/GUARDIAN INFORMATION

RELATIONSHIP TO PATIENT: ______________________________

LAST NAME: __________________________ FIRST NAME: ________________________ M.I. _____ SEX: ☐ M ☐ F

DATE OF BIRTH: _____________________ SOCIAL SECURITY NUMBER: _________________________

MAILING ADDRESS: ____
CITY: ____________________ STATE: _____ ZIP: ______________

HOME PHONE: ____________________ WORK PHONE: ___________________ CELL PHONE: _________________

OTHER PARENT/ GUARDIAN INFORMATION:

RELATIONSHIP TO PATIENT: ______________________________

LAST NAME: ___________________________ FIRST NAME: _______________________ M.I. _____ SEX: ☐ M ☐ F

DATE OF BIRTH: _____________________ SOCIAL SECURITY NUMBER: __________________________

MAILING ADDRESS: ____
CITY: ____________________ STATE: _____ ZIP: ______________

HOME PHONE: ____________________ WORK PHONE: ___________________ CELL PHONE: _________________

EMERGENCY CONTACT: _________________________ PHONE: ________________ RELATIONSHIP: ___________

PREFERRED METHOD OF CO-PAYMENT/DEDUCTABLE PAYMENT? ☐ Cash ☐ Check ☐ Credit Card

INSURANCE INFORMATION

We are happy to assist you in receiving your benefits by completing and submitting your claim forms. We need the following information:

PRIMARY INSURANCE:
INSURANCE NAME: ____ ID# ____________________________

GROUP #:_____________________________ POLICY HOLDER: ____

DATE OF BIRTH: ____________________ SEX: ☐ M ☐ F SOCIAL SECURITY: ________________________________

EMPLOYER & PHONE: ____

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PATIENT REGISTRATION FORM

SECONDARY INSURANCE:

INSURANCE NAME: ____ ID# ________________________
GROUP #:______________________________ POLICY HOLDER: ____
DATE OF BIRTH: ____________________ SEX: ☐ M ☐ F SOCIAL SECURITY: _________________________________
EMPLOYER & PHONE: ____

I authorize my insurance company to pay any benefits to Alaska Pediatric Surgery at 4100 Lake Otis Pkwy #206, Anchorage, AK 99508. I also authorize to release any medical information filed on my behalf. I authorize release of other medical records to Alaska Pediatric Surgery, LLC to facilitate payment of this account. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account and for any collections fees. I have reviewed all the information and completed the answers. I certify that this information is true and correct to the best of my knowledge, and I will notify you of any changes in the information.

______________________________________ ______________________

Signature of Acknowledgement Date

____

Employee Witness/Date

NOTICE OF PRIVACY PRACTICES

By my signature below I have acknowledged that I have been provided with Alaska Pediatric Surgery's Notice of Privacy Practices. I have had the opportunity to review and have my questions answered. A copy shall be provided to me upon my request.

____ __________________

Signature of Acknowledgement Date

____

Employee Witness/Date