Kristen Lee, MD
David Abel, DO • Rebecca Schultz, PA-C
35743 Kenai Spur Hwy., Ste. A, Soldotna, AK 99669
(907) 260-4468 • fax (907) 260-4467
www.upstreamfamily.org

Patient Information

Patient's Full Name: _____

Nickname/Name I prefer to be called: _____

Mailing Address: _____ Zip Code _____

Home Phone No.: _____ Cell Phone No.: _____

Work Phone No.: _____ Contact preference: Home Phone / Cell Phone / Work Phone / Mail

Email Address: _____

Birth Date: _____ Social Security No.: _____

Preferred Pharmacy: _____

Circle all that applies to the patient:

Gender: Male / Female **Primary Language:** _____

Marital Status: Single / Married / Widowed / Divorced / Legally Separated / Life Partner

Race/Ethnicity: American Indian / Alaskan Native / Asian / Black / African American / Native Hawaiian / Pacific Islander /

Caucasian / Hispanic / Latino / Patient Refusal / Other: _____

FOR MINORS: Parent/Guardian Information

Name: _____ Phone No.: _____ Relationship: _____

Name: _____ Phone No.: _____ Relationship: _____

FOR ADULTS: Emergency Contact Information

Name: _____ Phone No.: _____ Relationship: _____

Other providers and/or clinics visited in the last five (5) years:

_____

_____

Insurance Information

Insurance Plan: _____ ID # _____ Group # _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's Relationship to Patient: _____

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Acknowledgement and Authorization

Patient's Full Name: _____ **Date of Birth:** _____

Please initial each item, and sign and date below.

_____ I hereby consent to the rendering of such care, which may include routine diagnostic procedures and such medical treatments as the provider(s) consider being necessary under these circumstances. I authorize the provider(s) and other health care professionals to order and/or administer any treatment, local anesthetics, and/or perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of my injury or illness. This form has been fully explained to me, and I am satisfied that I understand its content and significance.

_____ I have read and understand the HIPAA/Privacy Policy for Upstream Family Medicine.

_____ I have read and understand the Financial Policy for Upstream Family Medicine.

_____ I hereby assign my insurance benefits to be paid directly to the healthcare provider.

_____ I authorize Upstream Family Medicine to release medical information required to process my claim.

_____ I authorize Upstream Family Medicine to obtain/have access to my medication history.

_____ I authorize Upstream Family Medicine to share my medical records with other electronic medical record systems. (This means Central Peninsula Hospital will have view-only access to my records.)

_____ I authorize Upstream Family Medicine to contact me by mobile phone.

_____ I authorize Upstream Family Medicine to contact me by secure e-mail.

Signed _____ **Date** _____

Witness _____ **Date** _____