Amy S. Elder APRN, WHNP-BC
Cari S. Miller, DNP, MPH, FNP-C
*851 E. Westpoint Drive, Ste 301*
*Wasilla, Alaska 99654-7183*
*Phone: 907-203-0044 Fax: 907-331-0505*
*Email:* office@karisalaska.com

# PATIENT DEMOGRAPHIC INFORMATION

| | | | |
|---|---|---|---|
| Full Legal Name: | | DOB: | |
| Previous/Maiden Name: | | SSN: | |
| Race:<br>☐ African American ☐ Asian ☐ Hispanic ☐ Native American<br>☐ Alaska Native ☐ Caucasian ☐ Mediterranean ☐ Other: | | Gender<br>M F | Marital Status<br>Single Married |
| Phone Number: | Alternate Number: | Preferred Pharmacy: | |
| Home Address: | | | |
| Emergency Contact Name: | Emergency Contact Phone: | Emergency Contact Relationship: | |

**IF PATIENT HAS A LEGAL GUARDIAN or HEALTHCARE PROXY PLEASE COMPLETE THE FOLLOWING:**

| | | |
|---|---|---|
| Legal Guardian Name: | | DOB: |
| Relationship to Patient: | Phone: | |
| Address: | | Primary Contact for Billing:<br>Yes No |

## Insurance Information:

| | | | |
|---|---|---|---|
| Billing Preference: Insurance Medicaid (Includes Denali KidCare) Self Pay | | | Primary Insurance: |
| Name of Policy Holder: | | | Secondary Insurance: |
| Relationship to Patient: | DOB: | Insurance ID #: | |

# Private Health Information

As our client we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take precautions to protect your private health information. When it is appropriate and necessary, we will provide the minimum information to only those we feel are in need of your health care information for treatment, payment or health care operations. I acknowledge that I have received, or had the opportunity to receive, a full copy of our **Notice of Private Policies (NoP).** I understand that I can obtain an additional copy of these rights from this office or my portal any time. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule gives individuals the right to request a restriction on uses of Private Health Information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternate means, such as sending correspondence to the individual's home, work, or fax, number. The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure for PHI to the minimum necessary to accomplish the intended purpose.

These provisions do not apply to uses made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. By supplying my phone number, email address, and any other personal contact information, I authorize my healthcare provider to disclose my PHI.

| Signature: | Date: |
|---|---|
| | |

**I authorize my healthcare provider to communicate my PHI in the following manner:**

| | | |
|---|---|---|
| Provider may mail my information to my mailing address: | Yes | No |
| Provider may leave a voicemail on my cell phone: | Yes | No |
| Provider may send information to email provided on page one: | Yes | No |

**Provider may release information to the following individuals**

| Name | DOB | Relationship | Phone Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Consent for Treatment And Financial Agreement**

I authorize the collective health care providers at Karis Integrative Medicine, LLC to render mutually agreed upon services as necessary for my care and/or my family.
I understand that I am responsible for all fees regardless of insurance. I understand that fees will be generated for all services rendered if paying with insurance; I am responsible for furnishing the insurance information correctly to the office prior to treatment unless other arrangements have been made in advance. I hereby authorize Karis Integrative Medicine, LLC to furnish information to insurance carriers concerning my illness/injury and treatment and hereby assign all payments for medical services rendered to myself and my dependents. I understand that Karis Integrative Medicine, LLC uses an outside billing service and I may be contacted by them for payment or additional billing related information.

| Signature: | Date: |
|---|---|
| | |

## Health Inventory

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

**Please list any other providers or hospitals you visit or have visited in the last 7 years.** This will help coordinate your care.

| Office Name | Provider Name | Reason for Appointment | Treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Allergies

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |

## Medications and Supplements

| Name | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**I consent to have my medication history imported: Yes No**

## Immunizations and Vaccinations

| Type | Date | Adverse Reactions |
|---|---|---|
| Covid 19 mRNA Shot | | |
| HPV | | |
| Flu | | |
| Childhood Immunizations | | |

| | |
|---|---|
| **Have you felt down, depressed or hopeless in the last 8 weeks?** | Yes No |
| **Have you felt little or no pleasure in things you normally enjoy?** | Yes No |
| **Have you thought about or made plans to hurt yourself?** | Yes No |
| **Have you thought about or made plans to hurt someone else?** | Yes No |

## Family History

| Relation | Age | Illnesses |
|---|---|---|
| Father | | |
| Mother | | |
| Paternal Grandfather | | |
| Paternal Grandmother | | |
| Maternal Grandfather | | |
| Maternal Grandmother | | |
| Sister | | |
| Brother | | |
| Child | | |
| Child | | |
| Other: | | |

## Medical History

| Illness | When | Illness | When | Illness | When |
|---|---|---|---|---|---|
| Alcoholism | | Eczema/Skin Condition | | Mononucleosis | |
| Anemia | | Epilepsy/Seizures | | Pneumonia | |
| Anxiety/Depression | | Gallstones | | Recurrent Infections | |
| Arthritis | | GERD/Acid Reflux | | Rheumatic Fever | |
| Asthma | | Heart Attack | | Scoliosis | |
| Autoimmune Disorder | | Hepatitis | | Sinusitis | |
| Bronchitis | | High Cholesterol | | Sleep Apnea | |
| Cancer: | | High Blood Pressure | | Stroke | |
| Chronic Fatigue Syndrome | | Irritable Bowels | | Substance Abuse | |
| Crohn's/Ulcerative Colitis | | Kidney Stones | | Thyroid Issues | |
| COPD/Emphysema | | Mental Delay/Illness | | Other: | |
| Diabetes | | Migraines | | Other: | |

## Surgical/Radiological History

| Surgery | Date | Surgery | Date | Surgery | Date |
|---|---|---|---|---|---|
| Appendectomy | | EEG | | Liver Scan | |
| Colonoscopy/Sigmoidoscopy | | Eye Surgery | | Mammogram/Thermogram | |
| Coronary Artery Bipass | | Hernia Repair | | MRI | |
| CT Scan | | Hysterectomy | | Orthopedic Surgery | |
| Dental Surgery | | Gall Bladder Removal | | Xray | |
| ECG/EKG | | GI Series | | Other: | |

## Women's Health

| Menstrual Cycle | | Diagnostic Testing and Birth Control | |
|---|---|---|---|
| What was your age when you had your first period? | | When was your last Pap? | |
| What was the first day of your last menstrual period? | | Were any of your past paps abnormal? | |
| Do you have a cycle every month? | | If abnormal, what was treatment? | |
| How long do your cycles normally last? | | When was your last mammogram/thermogram? | |
| Days from beginning of cycle to beginning of next? | | When was your last DEXA scan? | |
| On a scale of 0-10 how painful is menses for you? | | Current form of contraception? | |
| Are you premenopausal or menopausal? | | PMS symptoms: | |

**Pregnancy/OB**

| Have you been pregnant before? | | How many times have you been pregnant? | |
|---|---|---|---|

Full Term: Premature: Miscarriages: Abortions: Multiple Births: Living children:

| Delivery Date | Weeks Along | Labor Hours | Weight | Sex | Delivery Method | Delivery Facility | Complications |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
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## Men's Health

| Medical History | | Past procedures and STD Protection | |
|---|---|---|---|
| Have you ever experienced testicular torsion? | | Have you ever had a hernia repair? | |
| Other testicular problems (lumps, pain, discoloration)? | | Have you had a vasectomy? | |
| Do you have any history of prostate problems? | | Have you had a PSA blood test? | |
| Do you experience excessive urination? | | TURP(Transurethral Resection of the Prostate)? | |
| Do you have urinary incontinence? | | Have you ever had a digital rectal exam? | |
| Do you experience erectile dysfunction? | | Do you use protection during sexual activity? | |
| Do you experience difficulty with ejaculation? | | Concerns regarding your testosterone levels? | |

## Sexual Health

| Are you currently sexually active? | | How long have you been with your current partner? | |
|---|---|---|---|
| Have you ever been sexually active? | | Does your current partner have any other partners? | |
| How older were you at first intercourse? | | Do you use any barriers or STD protection? | |
| How many lifetime sexual partners? | | Do you have any history of STD's or UTI's? | |
| How many partners have you had in the last 5 years? | | Have you ever had nonconsensual sex? | |

Other sexual health concerns:

| Social | | | | |
|---|---|---|---|---|
| Do you or have you ever drank alcohol? | | Do you or have you ever smoked? | | **Please circle any of the following you have used in the past** |
| If yes, how often? | | What do you smoke? | | |
| How much do you drink in one sitting? | | How often do you smoke? | | Marijuana Cocaine |
| Do you feel like you should drink less? | | How much do you smoke? | | Ecstasy Benzodiazepines |
| **Lifestyle** | | | | Hallucinogens Heroin |
| Do you follow a special diet? | | Hours you are sleeping per night? | | Methamphetamines Opiates |
| Do you drink caffeinated drinks? | | Do you take naps? | | Anabolic Steroids |
| How much do you exercise? | | Do you feel rested after sleep? | | Other: |
| Do you have fitness concerns? | | Do you have hobbies you pursue? | | |

| Household | | | |
|---|---|---|---|
| How old is your home? | | Who do you live with? | |
| Do you drink city or well | | Do you have pets? (Please Describe) | |
| Are you exposed to mold at home? | | Are you exposed to dangerous chemicals? | |

## Please include any additional comments or concerns you may have:

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