Kabo Health, LLC.
Mountain View Urgent Care
3521 Mountain View Dr.
Anchorage, AK. 99508

Phone: 907-868-1105
Fax: 844-540-0938

Patient Information

Patient Registration

Last Name: _____
First Name: _____
Middle Name: _____
Sex: □ M □ F
Date of Birth: _____
Social Security #: _____
Address: _____
City: _____ State: _____
Zip: _____
Home Phone: _____
Mobile Phone: _____
Consent to leave detailed message □ Yes □ No
Work Phone: _____
Patient email: _____
Language: _____
Race: _____
Ethnicity: _____
Marital Status: □ Married □ Single □ Divorced □ Widowed □ Other
Preferred Pharmacy:_____

Responsible Party Information

Name: _____
Address: _____
City: _____ State: _____
Zip: _____
Relationship to patient: _____
Date of Birth: _____
Social Security #: _____
Phone: _____

Emergency Contact Information

Name: _____
Relationship: _____
Phone: _____
Mobile Phone: _____

Employer information

Employer: _____
Address: _____
City: _____ State: _____
Zip: _____
Phone: _____
Pharmacy location: _____

PRIMARY INSURANCE

Insurance Plan Name: _____
Last Name: _____
First Name: _____
Date of Birth: _____
Sex □ M □ F
Policy ID #: _____
Group Number: _____
Employer Name: _____
Patient's relationship to policy holder: _____

SECONDARY INSURANCE

Insurance Plan Name: _____
Last Name: _____
First Name: _____
Date of Birth: _____
Sex □ M □ F
Policy ID #: _____
Group Number: _____
Employer Name: _____
Patient's relationship to policy holder: _____

Reason for visit today: _____

PCP Name: _____ How did you hear about us: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

(Please read and sign)

I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government health benefits either to myself or to my physician who accepts assignment. I authorize payment of medical benefits to Kabo Health, LLC. (MVUC) for services provided. I understand that I am financially responsible for all charges whether paid or not by my insurance company.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

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Patient Consent for Treatment and for Use and Disclosure of Protected Health Information

I authorize medical treatment as deemed necessary and appropriate by the physicians of KABO HEALTH, LLC and their employees participating in my care. With my consent, Kabo Health, may use and disclose Protected Health Information (PHI), about me to carry out treatment, payment and healthcare operations. Please refer to the Kabo Health's Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, Kabo Health may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminder, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Kabo Health may relay any items that assist the practice in carrying out treatment, payment or healthcare operations such as appointment reminders, insurance items, statement reminders and any information pertaining to my clinical care, including laboratory results among others, to:

PLEASE LIST PERSON(S) THAT WE CAN SPEAK WITH ON YOUR BEHALF
(PLEASE LIST BOTH PARENTS OR GUARDIANS FOR MINOR PATIENTS)

Name	Relationship to Patient
Name	Relationship to Patient

With my consent, Kabo Health may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment or healthcare operations such as long as they are marked. With my consent, I authorize Kabo Health to release medical information regarding the care and treatment I have received from this office to the physicians I have listed on the reverse side of this form.

I have the right to request that Kabo Health restrict how it uses or discloses my PHI to carry out treatment, payment or healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I authorize payment of insurance benefits directly to Kabo Health. I understand that I am fully responsible for any medical or surgical charge incurred in the course of my treatment including those that are considered rejected, co-pay, deductible or other type of unpaid service in excess of any hospitalization or health insurance that might be applicable.

I hereby authorize my physician to release pertinent information to my health insurance companies required in the course of my examination or treatment. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Kabo Health has the right to decline to provide treatment to me. By signing this form, I am consenting Kabo Health's use and disclosure of my personal health information to carry out treatment, payment and healthcare operations. I acknowledge that I have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Patient/Legal Guardian Signature	Date
Printed Name of Patient	Printed Name of Legal Guardian

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Medical History Questionnaire

Patient Name: _____ DOB: _____

Current Medications/Herbs/Supplements: _____

_____

Allergies: Medication/Environmental/Food: _____

PCP: _____

Current Smoker (packs/day): _____ Former Smoker? (date quit): _____

Alcohol (drinks per week): _____ Other substance use: _____

Family Medical History: (Please specify family member, diagnosis, and approximate age of diagnosis): _____

Mother: _____ Father: _____

PERSONAL HEALTH HISTORY (Please indicate if you have a history of any of the following):

Neurological
□ Alzheimer's dementia
□ Seizures or epilepsy
□ Migraine headaches
□ Tension headaches
□ Stroke
□ Multiple Sclerosis

Skin
□ Acne
□ Cold sores
□ Eczema
□ Psoriasis
□ Rosacea
□ Skin cancer □ pre-cancer

Mental Health
☐ Anxiety
☐ Depression
☐ Addiction to drugs
☐ Alcoholism
☐ Insomnia

Eye, Ear, Nose, Throat
☐ Visual impairment
☐ Cataracts
☐ Glaucoma
☐ Hearing loss
☐ Sinusitis
☐ Ear infections

Lung and Respiratory
□ Asthma
□ Sleep apnea
□ Emphysema (COPD)
□ Tuberculosis □ positive PPD

Allergy, Immune
□ Seasonal or environmental allergies
□ Other allergies (specify): _____
□ Anaphylaxis
□ Urticaria (hives), frequent

Heart and Vascular
□ Hypertension (high blood pressure)
□ High cholesterol
□ Angina (cardiac chest pain)
□ Coronary disease □ heart attack
□ Atrial fibrillation ¨
□ Congestive heart failure

Hormonal
□ Diabetes
□ Osteoporosis □ osteopenia
□ Thyroid disorder
□ Vitamin D deficiency

Gastrointestinal
□ Diverticulosis □ diverticulitis
□ Colon polyps
□ Hemorrhoids
□ Hepatitis (specify type): ____
□ Irritable Bowel Syndrome
□ Reflux disease (GERD)
□ Ulcers, stomach or duodenal

Genitourinary, STD, Reproductive
□ Genital herpes
□ Genital warts
□ HIV/AIDS
□ Prior Chlamydia □ Gonorrhea
□ Syphilis
□ Infertility
□ Erectile dysfunction
□ Prostate enlargement (BPH) ¨
□ Endometriosis □ Menopause (age): _____
□ Urinary tract infections
□ Urinary incontinence
□ Vaginal yeast or infections

Musculoskeletal
□ Back pain
□ Gout
□ Neck pain
□ Osteoarthritis (specify locations): _____
_____
□ Rheumatoid arthritis

Cancers and Blood
□ Anemia (low blood count)
□ Blood clots (specify location): _____
□ Cancer (specify type): _____

Kidney
□ Kidney failure
□ Kidney stones

Review of System: (Please circle any symptoms you have experienced):

Excess weight gain, excess weight loss, loss of appetite, fever, fatigue, chills, night sweats, eye pain, eye discharge, blurry vision, ear pain, hearing loss, sore throat, hoarseness, mouth lesions, swallowing difficulty, chest pain, palpitations, cough, wheezing, chest tightness, pain with respiration, rapid respiration, sputum, abdominal pain, nausea, vomiting, diarrhea, constipation, heartburn, pain with urination, increase in frequency of urination, soft tissue swelling, joint swelling, myalgia, leg pain, leg swelling, chronic back pain, joint stiffness, neck pain, rash, hives, numbness, weakness, tingling, burning, headache, dizziness, loss of consciousness, coordination changes, memory changes, depression, anxiety, insomnia, temperature intolerance, eating concerns, bruising, abnormal bleeding, frequent thirst, sneezing, runny nose, swollen lymph nodes