PINNACLE NEUROLOGY & INFUSION

Dear _____,

Welcome to Our Practice!

We look forward to meeting with you. Attached is our new patient packet. This packet will allow our staff to better get to know you and identify your best treatment options. It will ask you about patient-specific health information, such as your demographics, insurance information, medical history, etc. The packet contains the following forms: cash pay policy, authorization of use/disclosure of protected health information (HIPAA), our office policy, and the late arrival policy. Please fill out these forms to the best of your ability prior to your first appointment.

*****New patient paperwork must be completed 15 minutes prior to your appointment start time. You may be rescheduled at the provider's discretion if your paperwork is not completed or if you arrive late.*****

You have been scheduled on _____ at _____ a.m/p.m for the following Appointment or treatment: _____
With: _____

If you are coming in to discuss memory issues it is important that you bring someone with you to the appointment.

Our clinic is located at **3505 E Meridian Park Lp, Suite 100, Wasilla, AK 99654.** We are on the first floor of the Ptarmigan II building. Meridian Park Loop is located just off Seward Meridian Parkway, between East Bogard Road and East Palmer Wasilla Highway.

If you have any questions regarding your appointment, please contact our friendly front desk staff at **907-864-0022**. We are happy to help in any way we can to ensure you have an exceptional experience at our clinic.

Thank you and again, we look forward to seeing you soon!

_____

Pinnacle Neurology and Infusion

PINNACLE NEUROLOGY & INFUSION

New Patient Demographic and Insurance information

Please complete these pages in their entirety. You may inquire at our front desk or call (**907) 864-0022** if you have any questions or are unsure how to complete any section of this form.

Patient Demographic Information

Last Name: _____ **First Name:**_____ **MI:**_____

Any previous names you have gone by? _____

DOB (MM/DD/YYYY)**:** _____ **SSN:** _____ **Gender:** ○ Male ○ Female

Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Mailing Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Email Address: _____

Primary Phone: _____ **Type:** ○ Home ○ Cell ○ Work

Secondary Phone:_____ **Type:** ○ Home ○ Cell ○ Work

Disabilities requiring special assistance: _____

Please describe the reason for your visit today:_____

_____

Who should we contact in the event of an emergency?

Emergency Contact: _____ **Relationship to Patient:** _____

Phone Number: _____ **Type:** ○ Home ○ Cell ○ Work

May we discuss your medical conditions with a member of your household? ○ Yes ○ No

If so, with whom? _____**Relationship to Patient:** _____

Phone Number: _____ **Type:** ○ Home ○ Cell ○ Work

Race:

○ American Indian or Alaskan Native ○ Asian or Pacific Islander ○ Caucasian or European American
○ African American ○ Decline to answer ○ Other:_____

Ethnicity:

○ Hispanic ○ Non-Hispanic ○ Decline to answer

Primary Language:

○ English ○ Russian ○ Spanish ○ Korean ○ Alaskan Native ○ Other: _____

Do you need an interpreter for your appointment? ○ Yes ○ No

Name: _____ DOB: _____ Date:_____

Insurance Information

Please bring your insurance card and photo ID; these are to be scanned in prior to your appointment

COMPLETE THIS FORM EVEN THOUGH WE HAVE COPIES OF YOUR INSURANCE INFORMATION. THIS IS TO PREVENT BILLING DELAYS/ERRORS.

Do you have Primary Insurance? ○ Yes ○ No **If yes, Insurance Name:**_____

Policy Holder Name: _____ DOB: _____

Relationship to patient: _____

Policy Number: _____ Group Number: _____

Do you have Secondary Insurance? ○ Yes ○ No **If yes, Insurance Name:**_____

Policy Holder Name: _____ DOB: _____

Relationship to patient: _____

Policy Number: _____ Group Number: _____

Do you have Tertirary Insurance? ○ Yes ○ No **If yes, Insurance Name:**_____

Policy Holder Name: _____ DOB: _____

Relationship to patient: _____

Policy Number: _____ Group Number: _____

RESPONSIBLE PARTY ***(if other than patient)***

Name: _____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____

Mailing Address: _____ Phone Number: _____

Referral Information / Primary Care Provider

Were you referred to our clinic by another physician? If so, whom?

Provider: _____ Clinic: _____

Who is your primary care provider (PCP)?

Provider: _____ Clinic: _____

When was the last time you saw your PCP?:_____ (Date)

PINNACLE NEUROLOGY & INFUSION

Name: _____ DOB: _____ Date:_____

New Patient Health History Information

Allergies

Topical Allergies: ○ Iodine ○ Latex ○ Tape/Adhesive **Are you allergic to shellfish?** ○ Yes ○ No

Please list all medication(s), food, or environmental allergies below or select "None" if none are known. ○ **None**

Medication or allergens

1)_____ Reaction:_____

2)_____ Reaction:_____

3)_____ Reaction:_____

4)_____ Reaction:_____

5)_____ Reaction:_____

Current Medications

Please include all prescribed medications, over-the-counter medications, and supplements you are currently taking. If you need more space to write medications, please use the medication extension sheet at the end of this packet.

Preferred Pharmacy: _____ **City:**_____

Please initial if you give our clinic consent to request and reconcile your prescription history **Initial:** _____

Name of Medication: Example: Metformin or Vitamin D	**Dose** Example: 25mg	**How Often?** Example: daily or evening	**Prescribing Provider** Example: Dr. Jackson

Name: _____ DOB: _____ Date:_____

Past Medical History

Have you been diagnosed by a medical professional with the following conditions or medical problems?

○ Yes, please indicate below. ○ No

Please indicate the date (MM/YYYY) of diagnosis on the provided line.

○ AIDS/HIV infection:_____
○ Alcoholism:_____
○ Anemia: _____
○ Angina:_____
○ Stable ○ Unstable
○ Anxiety:_____
○ Atherosclerosis: _____
○ Asthma:_____
○ Atrial fibrillation:_____
○ Back Pain (chronic: longer than 6 months): _____
○ Bipolar mood disorder: _____
○ Cancer:_____
○ Type: _____
○ Chronic kidney disease: _____
○ Cirrhosis:_____
○ Congestive heart failure:_____
○ COPD:_____
○ Coronary Disease:_____
○ Depression:_____
○ Diabetes:_____
○ Type 1 ○ Type 2

○ Diverticulitis:_____
○ DVT:_____
○ Emphysema: _____
○ Epilepsy (seizures): _____
○ GERD: _____
○ Fibromyalgia: _____
○ Gastric ulcer: _____
○ Glaucoma: _____
○ Gout: _____
○ Headache (chronic: longer than 6 months): _____
○ Hearing Loss:_____
○ Heart Attack: _____
○ Hepatitis A / B / C (circle one) Active / Inactive / Unsure _____
○ High cholesterol: _____
○ Hyperthyroidism: _____
○ Hypothyroidism:_____
○ Kidney Stones:_____
○ Lupus:_____
○ Lyme disease:_____
○ Migraines:_____

○ Mitral valve prolapse: _____
○ Multiple Sclerosis:_____
○ Neck Pain (chronic: longer than 6 months):_____
○ Osteoarthritis:_____
○ Osteoporosis:_____
○ Pacemaker:_____
○ Psoriasis: _____
○ PTSD:_____
○ Pulmonary embolism:_____
○ Rheumatoid arthritis: _____
○ Schizophrenia:_____
○ Seizures: _____
○ Sleep apnea: _____
○ Stroke: _____
○ Tuberculosis: _____
○ Active ○ Latent
○ Urinary Incontinence:_____
○ Vertebral Compression Fracture: _____
○ Other Diagnosis: _____
_____
_____
_____

If you selected any of the above diagnoses, are you currently being seen by a provider?

○ Yes, which condition and provider are you seeing? _____
_____
_____

○ No

Name: _____ DOB: _____ Date:_____

Hospitalizations / Surgical History

Have you ever been hospitalized or had any surgeries? ○ Yes, please indicate below. ○ No

Date of Surgery: (MM/YYYY)	**Type of Surgery / Procedure:** Example: Appendectomy, Hip replacement and etc.	**Hospital and Surgeon:**

Family History

Do you have any medical conditions that run in your family? ○ Yes, please indicate below ○ No

Family Member	**Health Condition**	**Alive or Deceased (Year)**
Father:		
Mother:		
Sibling(s): **Please specify if brother/sister**		
Children(s): **Please specify if son/daughter**		

Additional Information

Do you wear corrective eyewear? ○ Yes: _____ *(prescription glasses, reading glasses, etc.)* ○ No

Date of last eye exam: _____

Do you wear an assistive listening device or a hearing aid? ○ Yes ○ No

Name: _____ DOB: _____ Date:_____

Social History

Have you served or currently serving in the military? ○ Yes, Thank you for your service! ○ No

Branch of service: ○ Air Force ○ Army ○ Coast Guard ○ Navy ○ Space Force ○ Marine Corps

Were you ever stationed at an overseas assignment(s)? If so, what base and when.

○ **Base:** _____ **Country:**_____**Year:** _____

○ **Base:** _____ **Country:**_____**Year:** _____

○ **Base:** _____ **Country:**_____**Year:** _____

Highest level of education obtained: ○ Less than high school ○ High School ○ Some College ○ Associates ○ Bachelors ○ Masters/Professional Degree ○ Doctoral ○ Other: _____

Employment Status: ○ Full Time ○ Part Time ○ Retired ○ Student ○ Disability ○ Per Diem ○ Seasonal ○ None

Current Occupation: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Where do you live: ○ House ○ Mobile Home ○ Apartment ○ Assisted Living Facility ○ Other: _____

Others who live in your home: ○ Self ○ Spouse ○ Children ○ Parents ○ Relatives ○ Roommates ○ Other: _____

Do you have a support network? ○ Yes ○ No

If yes, who is your support individual: _____ Relationship:_____

Pets: ○ Dog(s):_____ ○ Cat(s):_____ ○ Other: _____

Habits

Smoking Status:

○ Never Smoked ○ Current Smoker ○ Former smoker ○ Vaping ○ Pouches/Chew

○ Other: _____

○ **Current smoker**, cigarettes per day:_____ for _____ years

○ **Former smoker**, how many years did/have you smoked:_____

Alcohol Use: ○ Yes ○ No

Type: ○ Beer ○ Wine ○ Liquor

How much: ○ Per day: _____ ○ Per week: _____ ○ Per monthly: _____ ○ Per year: _____

Name: _____ DOB: _____ Date:_____

Habits Continued

Caffeine Use: ○ Yes ○ No

Type: ○ Coffee ○ Energy Drinks ○ Soda ○ Tea ○ Other:_____

How much: ○ Per Day: _____ ○ Per Week: _____ ○ Per Month: _____ ○ Per Year: _____

Diet:

Type: ○ Regular ○ Diabetic / ADA ○ Vegetarian ○ Vegan ○ Dash ○ Kosher ○ High Carb ○ Low Carb ○ High Fat ○ Low Fat ○ Intermittent Fasting ○ Other: _____

Screen Time:

How many hours per day of screen time? ○ Under 1 hour ○ 1-2 hours ○ 3-4 hours ○ 4-6 hours ○ 6+ hours

Sleep Hygiene:

Average number of hours in bed / asleep per night? _____ hours

Quality of sleep? ○ Very Good ○ Good ○ Fair ○ Poor ○ Very Poor

Hydration:

How many ounces or cups of water do you drink per day? _____

Regular Exercise: ○ Yes ○ No

Type of exercise: _____

Intensity: ○ Light ○ Moderate ○ Vigorous

How often: _____

Drug / Illicit Substance Use: ○ Yes: _____ *(for how long)* ○ No

How often: ○ None ○ Occasional ○ Daily ○ Weekly ○ Monthly ○ Yearly

Type: ○ Marijuana ○ Other: _____

Have you ever abused narcotic or prescription medications?

○ No ○ Yes, what type and when: _____

Females Only

When was your most recent menstrual period?_____(date)

How long are your cycles? ○ 1-2 days ○ 3-4 days ○ 5-7 days ○ 8 days or longer ○ Irregular

Are you currently pregnant? ○ Yes ○ No

Are you planning on becoming pregnant in the next 6 months? ○ Yes ○ No

Are you currently breastfeeding? ○ Yes ○ No

Have you started or completed menopause? ○ Yes ○ No

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Name: _____ DOB: _____ Date:_____

Current Medications Extension Sheet

Please include all prescribed medications, over-the-counter, supplements or herbals you are currently taking. If you need more space to write medications, please request an additional medication page or bring in a current medication list to your appointment.

Name of Medication: Example: Metformin or Vitamin D	**Dose** Example: 25mg	**How Often?** Example: daily or evening	**Prescribing Provider** Example: Dr. Jackson

Please initial if you give our clinic consent to request and reconcile your prescription history **Initial:**

Pinnacle Neurology & Infusion
3505 E. Meridian Park Loop, Suite 100 Wasilla, AK 99654
– Phone: 907.864.0022 – **Fax**: 877.725.7371 – **Email**: contact@pnialaska.com –
Website: www.pnialaska.com