Michelle P. Thomas, MD, MSc, FACS
Confidential Health History

Name: _____ **Age**: _____ **DOB**: _____

Reason for visit: _____ **Height**: _____ **Weight**: _____

MEDICATIONS & SUPPLEMENTS (dosage & frequency)

ALLERGIES & REACTION

PRIOR SURGICAL HISTORY/HOSPITALIZATIONS/SERIOUS ILLNESS	
Year	***Reason***

HAVE YOU HAD COVID? Y/N, DATE _____ VACCINATED? Y/N, DATES: _____/BRAND:

HAVE YOU HAD A BLOOD TRANSFUSION? Y/N, DATE

CIRCLE THE CONDITIONS YOU NOW HAVE OR HAVE HAD IN THE PAST:		
AIDS	Glaucoma	Pacemaker
Alcoholism	Goiter	Pneumonia
Anemia	Gout	Polio
Arthritis	Heart Disease	Prostate Problems
Asthma	Hepatitis	Psychiatric Care
Bleeding Disorders	Hernia	Rheumatic Fever
Breast Lump	Herpes	Stroke
Bronchitis	High Cholesterol	Suicide Attempt
Cancer	HIV +	Thyroid Problem
Chemical Depend.	Hypertension	Tuberculosis
Chicken Pox	Kidney Disease	Typhoid Fever
Diabetes	Liver Disease	Ulcers
Emphysema	Multiple Sclerosis	Vaginal Infections
Epilepsy	Obesity	Venereal Disease

SOCIAL HISTORY	
Married/Single/Divorced?	
Kids Y/N How many?	Healthy?
Do you live alone/with family/with a	friend
Employment: Physical/desk?	
Exercise: _____mins/day _____days/week	Type of:
Cigarettes Y/N _____packs/day	Quit?
Chewing tobacco Y/N	Quit?
Alcohol Y/N ____drinks/wk	Quit?
Recreational drugs Y/N	Quit?

IF YOUR BLOOD RELATIVES HAVE HAD ANY OF THE FOLLOWING, PLEASE INDICATE	
Disease	***Relation to you***
Cancer/type	
Chemical Dependency	
Diabetes	
Heart disease, strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

PREGNANCY HISTORY		
Year	***Sex***	***Complications***
Are you pregnant? YES/NO		

Problems w/anesthesia? Y/N

Family h/o problems w/anesthesia? Y/N

Last Menstrual Period:

Last Mammogram:

I certify that the above information is correct to the best of my knowledge and that I will not hold my doctor or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE: _____ **DATE:** _____

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3340 Providence Dr., Suite 359 Anchorage, AK 99508

Past Medical History & Review of Systems (ROS)

Systemic
Current Symptoms:
___ Fever ___ Chills
___ Fatigue ___ Night sweats
___ Change in weight

EENT
Past Medical History:
___ Glaucoma ___ Hearing loss
Current Symptoms:
___ Headache
___ Neck pain/stiffness
___ Neck swelling/lump
___ Vision problems
___ Hoarseness
___ Sore throat

Endocrine:
Past Medical History:
___ Thyroid disease
___ Thyroid cancer
___ Adrenal tumor
___ Parathyroid disease
___ Osteoporosis
___ Diabetes
___ Gestational diabetes
Current Symptoms:
___ Heat or cold intolerance
___ Excessive thirst or urination
___ Excessive sweating
___ Change in libido (sex drive)
___ Change in shoe or ring size

Cardiovascular
Past Medical History:
___ High blood pressure
___ High cholesterol
___ Heart attack
___ Heart murmur ____ A-fib
___ Coronary Artery Disease(CAD)
___ On blood thinners
___ Blood clots ___ Angina
___ *EKG*
Date/Location: _____
___ *ECHO*
Date/Location: _____
Current Symptoms:
___ Chest pain
___ Palpitations

Gastrointestinal
Past Medical History:
___ C. Difficile
___ Crohn's disease
___ Peptic ulcer disease
___ Ulcerative colitis
___ Irritable Bowel Syndrome(IBS)
___ Esophageal reflux
___ Hepatitis
___ Gallbladder disease/gallstones
___ Colon cancer
___ Intestinal polyps removed
Date: _____
Current Symptoms:
___ Appetite changes
___ Difficulty swallowing
___ Heartburn
___ Abdominal pain
___ Nausea ___ Vomiting
___ Diarrhea ___ Constipation
___ Change in bowel habits
___ Bloody or black stools
___ Uncontrollable gas/bloating

Pulmonary
Past Medical History:
___ Asthma ___ Bronchitis
___ Emphysema ___ COPD
___ Sleep Apnea
___ History of TB
___ Abnormal chest X-ray/CT
Date/Location: _____
Current Symptoms:
___ Cough ___ Wheezing
___ Shortness of breath
___ Snoring
___ Excessive daytime sleepiness
___ Chest pain w/ deep breathing
___ Chest pain w/ rotating torso

Genitourinary
Past Medical History:
___ Urinary tract infection (UTI)
___ Kidney stones
Current Symptoms:
___ Blood in urine
___ Burning during urination
___ Change in urination

Neurological
Current Symptoms:
___ Dizziness ___ Fainting
___ Numbness
___ Sensory disturbances
___ Stroke ___ Seizure disorder

Psychological
Past Medical History:
___ Anxiety ___ Depression
Current Symptoms:
___ Sleep disturbances/Insomnia
___ Confusion
___ Memory lapse or loss
___ Other: _____

Musculoskeletal/Rheumatology
Current Symptoms:
___ Joint pain/stiffness
___ Joint swelling ___ Back pain
___ Muscle aches or weakness
___ Scleroderma
___ Other: _____

Skin:
Past Medical History:
___ Eczema ___ Psoriasis
Current Symptoms:
___ Itching ___ Rashes
___ Skin lesions ___ Lipoma/mass

Hematologic
Past Medical History:
___ Anemia ___ Easy bleeding

Other
___ HIV-1 infection/AIDS
___ MRSA

___ Refusal of blood products

Patient Signature: _____ Date: _____

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3340 Providence Dr., Ste. 359 Anchorage, AK 99508

1. **PATIENT INFORMATION:**

Last Name: _____ **First Name**: _____ **M.I**.____ DOB: _____

Mailing Address: _____ **Sex**: ☐ M □ F **Age**: _____

City/State/Zip: _____ Last 4 of SS #: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Preferred Pharmacy: _____

Current Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed ☐Partnered

Spouse's Name: _____ Last 4 of SS #: _____ DOB: _____

Emergency Contact/Relation: _____ Phone #: _____

Referred by: _____ Primary Care Physician: _____

Is this a work-related injury? ☐ Yes ☐ No If yes, date of injury: _____
Worker's Comp Insurance Name/Address: _____ Claim Number: _____

Is this auto or other accident? ☐ Yes ☐ No If yes, date of accident: _____

Are you a veteran? ☐ Yes ☐ No

2. **PERSON RESPONSIBLE FOR ACCOUNT:** ☐ Self ***If self, go to section 3***. ☐ Other

Last Name: _____ First Name: _____ DOB: _____
Mailing Address: _____ Last 4 of SS #: _____
City/State/Zip: _____ Home Phone: _____ Other Phone: _____

3.

	PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
Insurance name:	_____	_____
Policy ID & Group#:	_____	_____
Subscriber's Name:	_____	_____
Subscriber's DOB:	_____	_____
Relationship to Patient:	_____	_____

I consent to treatment necessary for the care of the above-named patient or myself. I hereby authorize the release of any information acquired in the course of this examination or treatment to the above-named insurance company and or physicians with care provided. If I have not paid for my treatment, I authorize the payment of medical benefits directly to Michelle Thomas M.D. I understand that I am responsible for all charges, regardless of insurance coverage.

SIGNATURE: _____ **DATE**:_____

MICHELLE P. THOMAS, M.D., M.Sc., F.A.C.S.
3340 PROVIDENCE DRIVE, SUITE 359
ANCHORAGE, ALASKA 99508
Ph: (907) 644-1033 Fax:(907) 644-0764

FINANCIAL AND INSURANCE POLICY

Patients with Insurance: Charges for your care or the care of a dependent are your responsibility. Our office will bill all insurance companies as a courtesy, as long as a copy of the current insurance card is provided by the patient at the time of service. It is your responsibility to provide us with up-to-date insurance information for our billing staff. Dr. Thomas is contracted only with Blue Cross, Aetna, United HealthCare, MODA, Cigna, Medicare Part B, & AK Medicaid. She is NOT a contracted provider for any other insurance companies. However, she does accept assignment from TRICARE & VA when referrals are received. We strongly recommend you contact your insurance company to verify your benefit coverage at our office. You may want to ask if they allow for exceptions of in-network coverage when there is not a contracted in-network general surgeon in your area. Your insurance coverage is **a contract between you and your insurance company** and is not a guarantee of payment. You should be aware of your obligation with them. Also, if you have not met your deductible, please inform the office staff.

- **AK Medicaid Recipients**: Medicaid insurance card is required for each visit. Your **co-payment of $3.00 is expected at time of service** from specific groups of Medicaid recipients. Please check with the office staff at **each** visit.

- **Billing procedures*:***
  1) If you are having surgery, we will bill your insurance company. **You should expect to receive at least two (2) different bills**: one from Dr. Michelle Thomas (your physician) and one from the facility where your procedure took place. If an anesthesiologist or pathologist was needed, you will receive a bill from each of them as well.
  2) Once we have received an explanation of benefits from your insurance company, you will be sent a statement from this office. Any remaining balance is the patient's responsibility.
  3) **At that time, full payment will be due upon receipt**. However, if you find it necessary, we can work out a reasonable and regular payment schedule we both find acceptable. You will be expected to notify this office to make arrangements.

Patients without Insurance: Patients being seen for a medical reason that does not have insurance will be expected to pay for their first consultation in full at the time of service. If surgery is necessary, each case will be addressed individually at that time to work out a payment schedule.

I have read and understand the above information. This policy is acceptable to me and I take responsibility for my health care and my financial obligations.

I hereby authorize Michelle P. Thomas, M.D., to furnish information to my insurance carrier(s) concerning my treatments and/or illness. I hereby assign to Dr. Thomas all payments for medical services rendered to me and/or my dependent(s).

I understand that I am responsible for all medical charges, regardless of my insurance coverage*.*

Print Name: _____

Signature: _____ **Date**: _____

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APPOINTMENTS

About Your Appointment: We make every effort for you to be seen at your scheduled appointment time, but occasionally situations arise that prevent this. We ask for your patience when this occurs. If there is an unusual delay, our staff will advise you. If you are unable to wait, we will gladly re-schedule your appointment for a later date/time.

Cancelling an Appointment: If you need to cancel an appointment, please advise us as soon as possible.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that a copy of the Notice of Privacy Practices provided by Michelle P. Thomas, MD is available for me to review. Hard copies are available in the blue binder on the table by the front desk.

Signature: _____ **Date**: _____

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I authorize Michelle P. Thomas, MD to use and/or disclose my health information to 1) Additional physician(s) for consideration of additional treatment, should it become necessary, 2) Myself, and/or

3) _____
(i.e. Family members, other physicians, etc.)

** The following items must be initialed to be included in the use or disclose of other health information:
____ HIV/HCV/AIDS/SEXUALLY TRANSMITTED related health information and/or records
____ Mental health information and/or records
____ Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of what information is requested to be released. Federal law prohibits the re-disclosure of such information.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the Practice Manager or the Privacy Officer. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand that this form does not supersede any previously signed Release of Information Forms.

I also understand that, if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. This authorization will expire one year from date signed unless otherwise specified.

Signature: _____ **Date:** _____