Health Services

Patient Registration Packet

Welcome to the Kodiak Area Native Association

Thank you for choosing KANA for your health care and social service needs. We deliver patient-centered care to the communities of Kodiak Island as part of our belief that healthy individuals live in healthy communities.

Our clinics provide health care in an outpatient setting to increase the accessibility and affordability of care for our communities. Health services are delivered through integrated medical care teams; which includes your provider, nurses, case managers, and behavioral health consultants. Your integrated medical care team will work closely with dental providers and behavioral health providers to ensure all of your health care and well-being needs are met.

REGISTRATION REQUIREMENTS

In order to best serve you, we ask that you register in advance of your first appointment. Registration packets are available to be picked up at any KANA location and are also available online. Completed registration packets may be retuned in person, by mail, or emailed to registration@kodiakhealthcare.org. If your registration packet cannot be completed prior to your first appointment, please arrive 15 minutes earlier to your schedule appointment time.

Please be prepared to provide a copy of the following documents.

☐State ID or Driver's License
☐Insurance Card(s)
☐DD214 to enroll in Veterans Administration (if applicable)
☐Medical Records (optional)

For further assistance or questions, please contact our registration staff at 907-486-9870.

Our mission is *"To Elevate the Quality of Life of the People We Serve."*

KODIAK AREA NATIVE ASSOCIATION
HEALTH SERVICES

☐New Patient ☐Update MRN:

Section 1: Patient Demographics

Last Name	First Name	Middle Initial	Suffix

Sex at Birth ☐Male ☐Female

Social Security Number

Birth Date

Ethnicity
☐Decline
☐Hispanic or Latino
☐Not Hispanic or Latino

Race *(check all that apply)*
☐Decline ☐Asian ☐Native Hawaiian
☐American Indian or Alaska Native ☐White ☐Other Pacific Islander
☐Black or African American

Mailing Address	City	State	Zip Code

Home Phone	Cell Phone	Preferred Phone: ☐Home ☐Cell ☐Other:

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

Veteran Status: ☐Yes ☐No

Homeless: ☐Yes ☐No

Public Housing: ☐Yes ☐No

Primary Language: ☐English ☐Tagalog ☐Spanish ☐Other:

Interpreter Required? ☐Yes ☐No

Email Address:

Section 2: Employment

Employment Status
☐Active Duty Military; ☐Disabled; ☐Full Time; ☐Part-Time; ☐Minor Child; ☐Reserve National Guard; ☐Self Employed; ☐Student; ☐Unemployed; ☐Unknown; ☐Decline; ☐Retired – Date:________________________________

Section 3: Household Income

By providing Household Income information, it will enable KANA to screen you for alternate funding sources that can assist with health care related costs, as well as help us to meet federal grant requirements. Please circle the number of people living in your household and your household income range on the same line where the household size is circled.
**Household Members, include: Patient, spouse, registered domestic partner, parents, and/or children.*
**Annual Income, includes: The total amount earned annually by all individuals making up the household number.*

Household Size	Less Than	Between	Between	Between	More Than
1	$15,600	$15,601 - $23,400	$23,401 - $27,300	$27,301 - $31,200	$31,201
2	$21,130	$21,131 - $31,695	$31,696 - $36,978	$36,979 - $42,260	$42,261
3	$26,660	$26,661 - $39,990	$39,991 - $46,655	$46,656 - $53,320	$53,320
4	$32,190	$32,191 - $48,285	$48,286 - $56,333	$56,334 - $64,380	$64,381
5	$37,720	$37,721 - $56,580	$56,581 - $66,010	$66,011 -$75,440	$75,441
6	$43,250	$43,251 - $64,875	$64,876 - $75,688	$75,689 - $86,500	$86,501
7	$48,780	$48,781 - $73,170	$73,171 - $85,365	$85,366 - $97,560	$97,561
8	$54,310	$54,311 - $81,465	$81,466 - $95,043	$95,044 - $108,620	$108,621

☐I choose to **DECLINE** to provide household income information.

Section 4: Emergency Contact

Emergency Contact Name	Emergency Contact Number	Emergency Contact Relationship

Section 5: Financially Responsible Party

Who is financially responsible for services: ☐Self (**skip**); ☐Parent (if patient is under 18yo); ☐Other, please specify:

Last Name	First Name	Birth Date	Gender ☐Male ☐Female	Social Security Number

Mailing Address	City	State	Zip Code	Phone

Section 6: Medical Insurance

Primary Medical Insurance	Group Number		Member ID Number	
Subscriber Full Name (if other than self)	Subscriber Date of Birth	Subscriber SSN		Co-Payment
Secondary Medical Insurance	Group Number		Subscriber ID Number	
Subscriber Full Name	Subscriber Date of Birth	Subscriber SSN		Co-Payment

Section 7: Dental Insurance

Primary Dental Insurance	Group Number		Member ID Number	
Subscriber Full Name (If other than self)	Subscriber Date of Birth	Subscriber SSN		Co-Payment
Secondary Dental Insurance	Group Number		Subscriber ID Number	
Subscriber Full Name	Subscriber Date of Birth	Subscriber SSN		Co-Payment

Section 8: Sliding Fee Discount Program

KANA offers a Sliding Fee Discount Program for individuals and families who are uninsured or underinsured. The Sliding Fee Discount Program includes flat rate fees for services (medical, dental, behavioral health) and is determined by an individual's ability to pay. A copy of the Sliding Fee Discount Program flat rate fees can be provided upon request.

Please check here if you are interested in learning more and/or completing an application ☐

Please check here if you are NOT interested in the Sliding Fee Discount Program ☐

Section 9: Additional Information

Providing the following information is **NOT** a requirement to receive care at KANA. If you do not want to provide this information, please select **DECLINE.** However, because KANA accepts federal funding, we are required to ask these questions to individuals 18 years and older; as well as provide the opportunity for patients of all ages to answer.

Gender Identity *(an individual's internal sense of gender/sex)*

☐Decline
☐Male
☐Female
☐Transgender Female/Male-to-Female
☐Transgender Male/Female-to-Male
☐Other

Sexual Orientation *(how an individual describes their emotional and sexual attraction to others)*

☐Decline
☐Straight (Heterosexual)
☐Gay/Lesbian (Homosexual)
☐Bisexual
☐Something else (Other)
☐Don't know

Section 10: Permission to Release Patient Information (18 Years & Older)

We will not give information out to anyone else but you unless their name(s) is written below and signed by you. This release of information does not include record requests to/from other doctor's offices, requests by insurance companies or other outside agencies; additional Release of Information Consent forms are required for these purposes.

***I hereby give permission to KANA to release the following information to those individuals listed below.* Check all that apply:**

☐ Discuss specialist referrals and appointments
☐ Verify or change my appointments
☐ Discuss prescriptions or medications
☐ Pick up or discuss test results
☐ Discuss dental treatment
☐ Discuss billing and payment information

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

***OR, I do not allow any information about me released to anyone*: ☐**

Patient /Guardian Signature:______________________________

Health Services

Section 11: Acknowledgements

Please Review and Initial the Following:

_______ **CONSENT FOR CARE**
I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my health care and will make my wishes known. I understand that KANA participates in the training of physicians and other health care providers and will be told when trainees take part in my care.

________ **NOTIFICATION OF RELEASE FOR PAYMENT**
I understand that KANA will disclose any diagnoses and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including medical, dental and behavioral health.

________**FINANCIAL AGREEMENT**
I understand that any applicable co-payments, sliding fee discount fees, and/or other associated charges are due at time of service. I assign payment from my insurance directly to KANA. I understand I am financially responsible to KANA for charges not paid by insurance and that payment for those charges is due within 30 days of receiving my bill. I understand that in addition to the bill from my provider, I may also receive separate bills from laboratory, radiology and other specialized services.

________**SLIDING FEE DISCOUNT PROGRAM**
I understand that KANA offers a sliding fee discount program for eligible individuals. The discount categories have been explained to me and I believe that the fees are reasonable. I have been given the opportunity to apply for this program.

________**NOTICE OF PRIVACY PRACTICES**
I acknowledge that I have been offered and have reviewed KANA's Notice of Privacy Practices that's been made available to me. I understand that I may request a copy of this notice at any time.

I have read the above and initialed my consent and financial responsibility for services at KANA. If I have a question about my visit or any financial liability I will contact KANA for clarification.

Date: ___________________________________ **Patient Signature:** ______________________________________

Parent/Guardian Signature: ______________________________

OFFICE USE ONLY

Staff Initials	____________________	☐Patient refused to sign
Patient MRN	____________________	☐Communication barriers prohibited obtaining acknowledgement
Date Entered into EHR	____________________	☐An emergency situation prevented obtaining acknowledgement
		☐Other: ________________________________

Kodiak Area Native Association

Health Services

New Patient History Form

Please complete the following information to the best of your knowledge. All information is confidential.

Patient's Full Name: ______________________ **Date of Birth:** __________ **Today's Date:** ________

Reason for Today's Visit:

____

____

Previous Hospitalizations/Surgeries/Serious Illness/Traumatic Events with dates:

____

____

Personal Medical History: *(please check all that apply)*

- ☐ ADHD
- ☐ Alcoholism
- ☐ Allergies, Seasonal
- ☐ Anemia
- ☐ Anxiety
- ☐ Arrhythmia *(irregular heart beat)*
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Autism
- ☐ Bipolar
- ☐ Bladder Problems/Incontinence
- ☐ Bleeding Problems
- ☐ Blood Transfusion
- ☐ Cancer:____________
- ☐ Crohn's Disease
- ☐ COPD/Emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Down Syndrome
- ☐ DVT (Blood Clot)
- ☐ GERD (Acid Reflux)
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heart Murmur or Heart Valve
- ☐ Heart Attack (MI)
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ HIV
- Hepatitis ☐ A ☐ B ☐ C
- ☐ Irritable Bowel Syndrome
- ☐ Lupus
- ☐ Liver Disease
- ☐ Macular Degeneration
- ☐ Neuropathy
- ☐ Osteopenia/Osteoporosis
- ☐ Parkinson's Disease
- ☐ Pacemaker
- ☐ Peripheral Vascular Disease
- ☐ Peptic Ulcer
- ☐ Psoriasis
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Sensory Disorders
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Ulcerative Colitis
- ☐ None of these
- ☐ Other: ________

Colonoscopy Date: ________ Normal/ Abnormal
Mammogram Date: ________ Normal/ Abnormal
Dexa *(Bone Density)* Date: ________ Normal/ Abnormal
Pap Date: ________ Normal/ Abnormal

Please list any diseases that run in your family (parents, siblings, grandparents)

____

____

Do you have allergies to any medications? If so, please list.

____

____

What prescription medications do you take? (Bisphosphonates, Nitroglycerin, etc.)

____

____

What other medication do you take? (Inhalers, vitamins, herbals, supplements, over the counter)

____

____

More About You

Do you use tobacco/vapes?	☐ Yes ☐ No	What kind?	How much/day? ______
Do you drink alcohol?	☐ Yes ☐ No	How often?	How much? ______
Do you use marijuana?	☐ Yes ☐ No	How often?	How much? ______
Have you ever used other drugs (i.e. non-prescribed, opioids, meth, heroin, etc.)?	☐ Yes ☐ No	What kind?	How much/ day? ______

Tell us about your exercise or physical activity routine:

____

____

Gender

☐ Decline ☐ Male ☐ Female ☐ Transgender Female/Male-to-Female ☐ Transgender Male/ Female-to-Male ☐ Other

Sexual Orientation

☐ Decline ☐ Heterosexual *(Straight)* ☐ Homosexual *(Gay/Lesbian)* ☐ Bisexual ☐ Don't Know ☐ Something else

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐Graduate / Professional

Are there any vision problems that affect your communication? ☐ Yes ☐ No

Are there any hearing problems that affect your communication? ☐ Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐ Yes ☐ No

Current Living Situation *(Please check all that apply):*

☐ Single Family Household ☐Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: __________

Recent Medical Symptoms: *(Please check all that apply)*

General Symptoms
- ☐ No problems with weight/fever/fatigue
- ☐ Recent weight change: ________
- ☐ Fever
- ☐ Fatigue/Poor energy

Eyes
- ☐ No problems with eyes
- ☐ Eye disease or injury
- ☐ Wear glasses
- ☐ Wear contact lenses
- ☐ Blurred vision

Ear/Nose/Throat/Mouth
- ☐ No problems with ear/nose/throat/mouth
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Sinus pressure
- ☐ Bleeding gums/nose bleed
- ☐ Snoring
- ☐ Jaw/Mouth/Tooth Pain

Pain Level (1-10): ________

Lungs/Breathing
- ☐ No problems with lungs/breathing
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing/asthma
- ☐ Coughing up blood

Heart/Circulation
- ☐ No problems with heart
- ☐ Chest pain or discomfort
- ☐ Shortness of breath
- ☐ Light headed/fainting
- ☐ Racing heartbeat (palpitations)

Stomach/Digestion
- ☐ No problems with stomach/digestion
- ☐ Nausea or vomiting
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Loose stool or diarrhea
- ☐ Red blood in bowel movement
- ☐ Heartburn

Bones/Muscles/Joints
- ☐ No problems with bones/muscles/joints
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Difficulty walking
- ☐ Osteoporosis

Bone scan date: ____________

Brain/Emotions/Nerves
- ☐ No problems with brain/emotions/nerves
- ☐ Headaches
- ☐ Tremors
- ☐ Numbness or tingling
- ☐ Depression
- ☐ Anxiety/nervousness
- ☐ Abuse/neglect
- ☐ Having trouble sleeping
- ☐ Loss of balance
- ☐ Memory loss
- ☐ Dizziness or lightheaded

Urine/Sexual
- ☐ No problems with urine/sex
- ☐ Pain during urination
- ☐ Blood in urine
- ☐ Change in urine
- ☐ Loss of urine
- ☐ Sexual difficulty

Male
- ☐ No problems with testicles
- ☐ Testicle pain
- ☐ Urination at night

Female
- ☐ No problems with vaginal discharge/itching
- ☐ Vaginal discharge or itching
- ☐ Breast problems

Last menstrual period date: ________

Periods are:
- ☐ Regular
- ☐ Irregular
- ☐ Menopause

Length of Menses: ________ # of days

Monthly Cycle: ________ # of days

Number of pregnancies: ________

Number of live births: ________

Skin/Breast/Immune System
- ☐ No problems with skin/breast/immune system
- ☐ Itching skin rash or sores
- ☐ Change in mole