



2841 DEBARR ROAD | SUITE 100 | ANCHORAGE, AK 99508 | (907) 276 - 2400

PATIENT INFORMATION

Patient Name _____ D.O.B. ____ / ____ / ____ SSN ____ - ____ - ____

Mailing Address _____

City _____ State _____ Zip Code _____

Hm Phone _____ Wk Phone _____ Cell Phone _____

Local Phone _____ May we leave a message on your recorder? Yes No Email _____

Employer _____ Occupation _____

Referring Physician _____

Do you have a hospital preference? _____ Pharmacy? _____

Parent/Legal Guardian (if not patient) _____

Marital Status Married Single Widowed Divorced Sex Male Female

If married, Spouse's Name _____ May we contact? Yes No

Emergency Contact

Name _____ Phone _____ Relationship _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance _____ Ins. Phone _____

Policy Holder _____ Policy Holder's SSN ____ - ____ - ____

Policy # _____ Group # _____

Policy Holder's DOB ____ / ____ / ____ Policy Holder's Employer _____

SECONDARY INSURANCE

Insurance _____ Ins. Phone _____

Policy Holder _____ Policy Holder's SSN ____ - ____ - ____

Policy # _____ Group #: _____

Policy Holder's DOB ____ / ____ / ____ Policy Holder's Employer _____

PATIENT PAYMENT AGREEMENT

I understand that I am responsible for my medical bill and accept responsibility for any charges not covered and paid by my insurance company or other third party resources.

- If my insurance company requires pre-certification/authorization for services, I understand that it is my responsibility to obtain that authorization prior to the scheduled appointment.
- By signing below, I authorize the release of my medical records to the insurance carrier as may be necessary to determine benefits and to process claims for health care services provided to the above named patient.
- I authorize assignment of Medicare/Medicaid, other federal/state agents or any commercial insurance carriers to pay benefits directly to the provider of service(s).
- This is a Lifetime insurance authorization granting the provider authority to file claims on my behalf.

In addition to the above patient payment agreement, I sign below acknowledging receipt of the office's NOTICE OF PRIVACY PRACTICES

Signature _____ Date _____

Witness _____ Date _____