



2490 S. WOODWORTH LP. | SUITE 150 | PALMER, AK 99645 | (907) 745-2900

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work 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 \_\_\_\_\_