ALASKA OB-GYN ASSOCIATES, LLC
PATIENT INFORMATION

PATIENT NAME	SSN	MARITAL STATUS S M W D Sep	DOB	AGE

MAILING ADDRESS	CITY & STATE	ZIP	HOME PHONE	Cell

PATIENT EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?	WORK PHONE

SPOUSE/PARENT NAME (IF APPLIC)	DOB	SSN

SPOUSE/PARENT EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?	WORK PHONE

EMERGENCY CONTACT NAME AND PHONE NUMBER _____
CELL PHONE/PAGER NUMBER SO WE MAY REACH YOU WITH AN URGENT MESSAGE _____

DO YOU HAVE INSURANCE COVERAGE? Y N
DO YOU HAVE MEDICARE? Y N
DO YOU HAVE MEDICAID? Y N

PRIMARY INSURANCE: (COPY OF CARD REQUIRED)

PLAN NAME: _____
ADDRESS: _____
POLICYHOLDER NAME: _____
SSN/ID # _____
GROUP NAME & NUMBER _____

SECONDARY INSURANCE: (COPY OF CARD REQUIRED)

PLAN NAME: _____
ADDRESS: _____
POLICYHOLDER NAME: _____
SSN/ID # _____
GROUP NAME & NUMBER _____

PLEASE BE ADVISED: PAYMENT IS DUE AT THE TIME OF SERVICE. WE WILL COPY YOUR INSURANCE CARD TO KEEP ON FILE.

MEDICAID STICKERS REQUIRED (APPLY HERE)

Have you ever been seen in this office under a different name? _____

Who were you referred by? _____

All professional services rendered are charged to the patient, including lab fees. Necessary forms will be completed by expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. I hereby authorize Alaska OB-GYN Associates, LLC to furnish information to insurance carriers concerning my illness and treatment. I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. There will also be a $25.00 NSF fee for all returned checks.

DATE _____ SIGNATURE _____