PATIENT INFORMATION

Name: _____ **Patient ID #:** _____ **Sex:** ☐M ☐F

Mailing Address: _____ **Date of Birth:** _____ **Age:** ____

_____ **Social Security #:** _____

City,State, Zip: _____ **Marital Status:** ☐Married ☐Single ☐Divorced ☐ Other

Home Phone: _____ **Email:** _____

Work Phone: _____ **Referral Source:** _____

Mobile/Pager Phone: _____ **Preferred Pharmacy** _____

PATIENT EMPLOYMENT INFORMATION

☐**Employed** ☐**Retired** ☐**Unemployed** ☐**Other**

Employer's Name: _____

Employer's Phone: _____

Occupation:

EMERGENCY CONTACTS

Name	Relationship	Phone

RESPONSIBLE PARTY *(If patient is under 18 years of age)*

Name: _____ M ☐ F ☐ **Employer:** _____

Address: _____ **Home Phone:** _____

_____ **Work Phone:** _____

City,State, Zip: _____ **SSN:** _____

Date of Birth: _____

PRIMARY INSURANCE

Insurance Company Name: _____

ID #: _____

Group/Policy #: _____

Subscriber's Name: _____ M ☐ F ☐

Subscriber's Phone #: _____

Relationship to Insured: _____

Subscriber's Employer: _____

Subscriber's SS #: _____

Subscriber's Date of Birth: _____

SECONDARY INSURANCE

Insurance Company Name: _____

ID #: _____

Group/Policy #: _____

Subscriber's Name: _____ M ☐ F ☐

Subscriber's Phone #: _____

Relationship to Insured: _____

Subscriber's Employer: _____

Subscriber's SS #: _____

Subscriber's Date of Birth: _____

Is there anyone else we can speak to regarding this account? ☐Billing ☐Medical ☐Scheduling

Name	Relationship	Date of Birth

INSURANCE AUTHORIZATION AND ASSIGNMENT

(Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to Medical Park Family Care, and authorize the clinic to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.***

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

Medical Park Family Care, Inc. 2211 E. Northern Lights Blvd
Anchorage, AK 99508