

Alaska Urgent Care
300 E Dimond Blvd, #12A
Anchorage, AK 99515
Ph: (907)341-7757 Fax (907)941-7760

DEMOGRAPHIC FORM

Patient name: _____ SS#: _____
First name Middle initial Last name

Mailing Address: _____

City: _____ State: _____ Zip: _____ Patient's Employer: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Date of Birth: _____ Sex: M F

Emergency Contact: _____ Phone Number: _____

GUARANTOR/BILLING INFORMATION

Person responsible for patient: _____ Sex: M F

Relationship to patient: _____ Date of Birth: _____ SS#: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ ID #:

GP #: _____

Name of Policyholder: _____ Relationship to patient: _____

SS#: _____ Date of Birth: _____ Sex: M F

Mailing Address & Phone # _____

(if different from patient): _____

Secondary Insurance Company: _____

ID #: _____ GP #: _____

Name of Policyholder: _____ Relationship to patient: _____

SS#: _____ Date of Birth: _____ Sex: M F

Mailing Address & Phone # _____

(if different from patient): _____

HIPAA PRIVACY RULE CONSENT, INFORMATION DISCLOSURE, AND INSURANCE AUTHORIZATION

All information provided by the patient is deemed private under the Health Insurance Portability and Accountability Act (HIPAA) and will be used as follows only with patient consent. I hereby authorize Alaska Medical Clinics, LLC, dba Wasilla Medical Clinic, to furnish information to other providers, healthcare or treatment facilities, and my insurance companies for purposes of treatment, payment, and healthcare operations. I hereby assign to the physician all payments for medical services rendered to myself and/or my dependents. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Patient/Guardian Signature

Date