Wasilla Medical Clinic
1700 E. Parks Hwy #200 Wasilla,
AK 99654
(907)373-6055 Fax (907)373-6077

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