3841 Piper Street Suite T300 Anchorage, AK 99508 PH (907)563-3103 FAX (907) 561-1862

PATIENT INFORMATION RECORD

Patient's Name: ____ SEX: **M F**

Date of Birth: ____________ Age: ________ SS#: _____-_____-______ Referred by: ________________

Physical Address: ______________________________ City: ______________ State: ______ Zip: ______

Mailing Address: _______________________________ City: ______________ State: ______ Zip: _______

Home Phone: (_____)______-________ Work: (_____)______-________ Cell: (_____)______-________

Employer: ______________________ Occupation: _____________________

Marital Status: **M W D S** Spouse's Name (if applicable): _____________________________

In case of Emergency, contact: ___________________ PH#(_____)______-________ Relation:__________

INSURANCE INFORMATION

Is this related to a Work Comp claim? **Y**es **N**o -or- Motor Vehicle Accident? **Y**es **N**o

Primary Insurance Carrier: ____________________________ Insured Name: ________________

Insurance ID#: ____________________________ Group#:___________ Insured DOB:____________

Relation to insured (circle one): **self spouse child other**

Secondary Insurance Carrier: __________________________ Insured Name: ________________

Insurance ID#: ____________________________ Group#:___________ Insured DOB:____________

Relation to insured (circle one): **self spouse child other**

PATIENT CONSENT/ASSIGNMENT: I hereby authorize Alpine Urology to release any information acquired in the course of my treatment to/from my insurance company, physician's office, hospital or any other treatment facility. I agree to be fully responsible for all expenses incurred for medical treatment. I assign to Alpine Urology any and all insurance benefits due to me, the full financial obligations for medical treatment that I have not paid for.

Printed Name: ____________________ **Signature:** ________________________ **Date:** ____________

NOTE: If you are the parent/guardian or legal representative for the patient, please complete your information on reverse side of this form.

THIS FORM IS TO BE UPDATED ANNUALLY

PARENT/GUARANTOR INFORMATION

Full Name: ____ SEX: **M F**

Date of Birth: _______________ Age: __________ SS#: ______-_____-_______

Physical Address: ____________________________________ City: _________________ State: ________ Zip: ________

Mailing Address: ______________________________________ City: _________________ State: _______ Zip: _________

Home Phone: (______)_______-_________ Work: (______)_______-_________ Cell: (______)_______-_________

Employer: __________________________ Occupation: _________________________

Marital Status: **M W D S** Spouse's Name (if applicable): ___________________________________