CONFIDENTIAL

ALASKA SINUS CENTER

OTOLARYNGOLOGY, FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

2401 EAST 42ND AVENUE, SUITE 206, ANCHORAGE, ALASKA 99508
TELEPHONE (907) 562-1860 • FAX (907) 562-1865

PATIENT INFORMATION

PATIENT NAME _____ S.S.# LAST 4 _____

AGE _____ SEX _____ DOB: ____/____/_____ REFERRING DR. _____

RESIDENCE _____ ZIP _____ PHONE_____

MAILING ADDRESS _____ ZIP _____ CELL # _____

RESPONSIBLE PERSON _____ S.S #_____ RELATION _____

EMPLOYER _____ OCCUPATION _____ PHONE _____

SPOUSES NAME _____ S.S. # _____ WORK # _____

NEAREST RELATIVE _____ RELATION _____ PHONE _____

PLEASE LIST EMERGENCY CONTACT NOT LIVING WITH YOU

NAME _____ PHONE _____

ADDRESS _____

INSURANCE INFORMATION

1) PRIMARY INSURANCE_____ PHONE # _____

ADDRESS _____ DEDUCTIBLE $_____ MET? YES NO

NAME OF INSURED _____ ID# _____ GROUP # _____

INSUREDS D.O.B._____ RELATION OF PATIENT TO INSURED _____

2) SECONDARY INSURANCE _____ PHONE # _____

ADDRESS _____ DEDUCTIBLE $_____ MET? YES NO

NAME OF INSURED _____ ID# _____ GROUP # _____

INSUREDS D.O.B._____ RELATION OF PATIENT TO INSURED _____

AUTHORIZATIONS

I authorize Alaska Sinus Center to release medical records required by my insurance company(s) and to my referring physician. I authorize my insurance company(s) to pay benefits directly to Alaska Sinus Center. I agree that a reproduced copy of this authorization will be as valid as the original. I understand I am responsible for any amount not covered by my insurance and any reasonable collection agency or attorney fees incurred. Charges not paid within 30 days are subject to 1.5% finance charge per month. This information may be released to a collection agency and/or credit bureau in the event my bill is not paid in a timely manner.

_____

PATIENT OR RESPONSIBLE PARTY

_____

DATE