PATIENT CONFIDENTIAL INFORMATION

Name _____
First Middle Last

Mailing Address _____
Street City State Zip

Home phone _____ Business Phone _____

Cell Phone _____ E-mail _____

Date of Birth _____ Sex: F M Marital status S M D W

Employer/ School_____

Nearest Relative not living with you: _____

Address _____ Phone _____

In case of emergency call : _____ Phone _____

My insurance does not cover any of the services of ANC Clinic, and I will pay in full at each visit.

Signature _____

My insurance does cover some of the services of ANC Clinic., and I authorize Alaskan Natural Care, Inc. to bill my insurance company, and receive and deposit payments on my behalf. I understand I am responsible for services not covered my insurance such as co-pays, deductibles, and non-covered amounts and services.

Signature _____

Patient's relationship to Insured [ ] Self [ ] Spouse [ ] Child [ ] Other

Insured's Name _____Insured's Date of Birth_____
(For Worker's Comp Claim, this would be the employer)

Insured's Address _____
Street City State Zip

Insurance Plan/Program Name _____Phone _____

ID # _____ Group Number _____

Employer Name _____

Chief Complaint _____

Complaint result of: [ ] Auto accident [ ] Injury [ ] Job-related [ ] Other

Date of accident / Injury / Other _____ /_____ /_____

Have you seen any other doctor about this condition? _____ If yes, when? _____

Doctor's name _____ Were you referred by your physician? Y N

Have you had recent x-rays or MRI? Y N If yes, when? _____ Area imaged _____

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with State Statutes, for the care and management of this complaint.

DATED _____ PATIENT'S SIGNATURE _____
(parent's signature if patient is a minor)