Patient Information Sheet

Patient ID: _____

Name: _____ **Preferred Name:** _____

DOB: _____ **Sex:** _____ **Marital Status:** _____

S.S.#: _____ **Drivers License #, State:** _____ , _____

Religion: _____ **Primary Language:** _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American

☐ Nat Hawaiian/Pacific Islander ☐ Other Race ☐ White ☐ Declined

Address On File: _____ **Current Address:** _____

City, St, Zip _____ **City, St., Zip** _____

Email: _____

Initial if Address On File is Current Address _____

Home #: _____ May we Leave Medical Message? Y/N

Cell #: _____ May we Leave Medical Message? Y/N

Work #: _____ May we Leave Medical Message? Y/N

Initial if Above is Correct _____

Preferred Pharmacy: _____ **Location:** _____

Emergency Contact: _____ **Emerg Phone:** _____ **Relationship:** _____

Doctor: _____ Referred By: _____

Signature: _____ Date: _____

Patient Information Sheet

Patient ID: _____

Primary Insurance Information

Insurance Co: _____

Policy ID #: _____ **Group #:** _____

Insured Information (If Different from Patient)

Policy Holder: _____ **Policy Holder DOB:** _____ **Policy Holder SSN:** _____

Address: _____

City, St., Zip: _____

Secondary Insurance Information

Insurance Co: _____

Policy ID #: _____ **Group #:** _____

Insured Information (If Different from Patient)

Policy Holder: _____ **Policy Holder DOB:** _____ **Policy Holder SSN:** _____

Address: _____

City, St., Zip: _____ **Initial if Above is Correct** _____

Authorization and Assignment

I assign all medical and/or surgical benefits to which I am entitled, including private insurance and any other health plan, to Alaska Women's Health. This assignment will remain in effect until revoked in writing by me. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment.

I understand that I am financially responsible for all charges incurred from medical treatment at Alaska Women's Health, whether or not the services are paid by my insurance. If, for any reason, it becomes necessary for Alaska Women's Health to engage an attorney or collections agency to secure payment from me, I agree to pay all reasonable interest charges, attorney fees, and collection costs.

_____ / / _____

Patient or Guardian Signature **Date**

Medicare Patients ONLY

I request that payment authorized by Medicare/Medigap benefits be made on my behalf to Alaska Women's Health for services furnished to me by a licensed provider. I authorize Alaska Women's Health to release any information required to determine these benefits payable for related services.

_____ / / _____

Patient or Guardian Signature **Date**

HIPAA Acknowledgement

(Please Initial) I acknowledge that I have been provided a Notice of Privacy Statement, Patient Rights and the opportunity to ask questions. I understand that I may request and review the detailed HIPAA Privacy Policy for Alaska Women's Health.

Optional: I hereby give Alaska Women's Health, PC authorization to release my information to the individual(s) listed below (i.e., spouse, parent, guardian, friend, etc.) Information MUST be specified as "Financial" and/or "Personal" or no information will be released. Financial information refers to billed charge totals ONLY (meaning the reason for the charge will not be released). Personal information refers to all non-financial information in regards to you as our patient (i.e., scheduled appointment times, lab results, etc.).

☐ Financial Information ☐ Personal Information Name: _____ Relationship: _____

☐ Financial Information ☐ Personal Information Name: _____ Relationship: _____

☐ Financial Information ☐ Personal Information Name: _____ Relationship: _____

I certify that the above information is correct to the best of my knowledge and belief:

_____ / / _____

Patient or Guardian Signature **Date**