



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: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Referred by: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*Is it ok to call you at this number? **Y N** Leave a message? **Y N**

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \* Is it ok to call you at this number? **Y N** Leave a message? **Y N**

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \* Is it ok to call you at this number? **Y N** Leave a message? **Y N**

**In case of Emergency, contact:** \_\_\_\_\_ PH#(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relation: \_\_\_\_\_

**INSURANCE INFORMATION**

Is this related to a Work Comp claim? **Yes No** -or- Motor Vehicle Accident? **Yes No**

**Primary** Insurance Carrier: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

**Secondary** Insurance Carrier: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

**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.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ / \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ / \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ / \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Initials / Date**

**Initials / Date**

**Initials / Date**

**Initials / Date**

**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): \_\_\_\_\_