



Alaska Bone & Joint Institute

2741 DeBarr Rd, Suite C-210 Anchorage, AK 99508

Phone: (907) 334-6788

Fax: (907) 334-6766

Billing Office: (907) 751-3704

Account #:

Today's Date:

PATIENT REGISTRATION

(Please **PRINT** Clearly)

Patient's Name: Last First MI			Sex: M F		Age:	Birthdate:
Patient's Mailing Address: Street Name		Apt #:	Social Security #:		Home Phone: ()	
City:	State:	Zip Code:	Country:		Message/Cell Phone: ()	
Patient's Employer:			Occupation:		Work Phone: ()	
Employer Address:			City:	State:	Zip Code:	
Spouse/Parent's Name: (Circle one)			Spouse/Parent's Address: (If different than patient's)			
Spouse/Parent's Employer:		Employer's Address:			Work Phone: ()	
Emergency Contact Name:			Relationship To Patient:		Emergency Contact Phone: ()	
Referred by:						

Primary Insurance

Secondary Insurance

Insurance Company Name:		Insurance Company Name:	
Insurance Address:		Insurance Address:	
Insurance Phone: ()	Group #:	Insurance Phone: ()	Group #:
Subscriber Name:	ID #:	Subscriber Name:	ID #:
Subscriber Birthdate:	Subscriber Employer:	Subscriber Birthdate:	Subscriber Employer:
Accident Related? Yes or No	Auto Accident? Yes or No	Date of Injury:	Claim Adjuster and/or Claim #

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF THE INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

<u>Insurance Authorization and Assignment (Please read and sign):</u>	
I hereby authorize Ak Bone & Joint Institute to furnish information to insurance carriers concerning my illness and/or treatments and I assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.	
Patient Signature: _____	Date: _____

How do you plan to pay?(Circle one) *Cash* *Check* *Visa* *MasterCard*