ALASKA FAMILY SONOGRAMS, INC.

WELCOME

(907) 561-3601

Fax: 561-3900

Date:_____/_____/_____

Patient's Last Name:_____ Patient's First Name_____ Middle Initial _____

Sex: ☐ F ☐ M ☐ Minor ☐ Single ☐ Married ☐ Widowed

Date of Birth:_____/_____/_____ Age:_____ Social Security #:_____-_____-_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Work Phone #: (_____)_____-_____ Ext._____ Home Phone #: (_____)_____-_____

Cell Phone #: (_____)_____-_____ Referring Physician:_____

Name of Employer:_____

Name of Spouse:_____ Work Phone #: (_____)_____-_____

Spouse's Employer:_____ Spouse Cell Phone #: (_____)_____-_____

Friend or Relative:_____ Telephone #: (_____)_____-_____

PRIMARY INSURANCE

Name of Person Insured Or Responsible Party:_____ Insured's Birthdate:_____/_____/_____

Insured's Address:_____ Zip Code_____

Insured's Employer:_____ Work Phone #:(____)_____-_____

Social Security #:_____-_____-_____ Relationship to Patient:_____Self_____Spouse_____Parent

SECONDARY INSURANCE

Name of Person Insured Or Responsible Party:_____ Insured's Birthdate:_____/_____/_____

Insured's Address:_____ Zip Code_____

Insured's Employer:_____ Work Phone #:(____)_____-_____

Social Security #:_____-_____-_____ Relationship to Patient:_____Self_____Spouse_____Parent

How did you hear about us?_____

_____Yes _____No It is okay to leave a message on my voice mail at home or on my cell phone.

_____Yes _____No I give AFS permission to release my medical information to my spouse.

I hereby authorize payment directly to Alaska Family Sonograms, Inc. of all insurance benefits otherwise payable to me for the services rendered. I understand I am financially responsible for all charges rendered on my behalf or my dependents, whether or not paid by insurance, and including any and all noncovered services.

I authorize the above noted supplier of services to release information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

I also acknowledge receipt of the Notice of Privacy Practices for Alaska Family Sonograms, Inc.

Signature of Responsible Party:_____