ALASKA FAMILY
SONOGRAMS, INC.
Leading-edge ultrasound. Unsurpassed commitment.

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

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

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

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone #: (_____) _____ - _____ Email:_____

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

Referring Physician: _____

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

Friend/Relative:_____ Phone #: (_____) _____ - _____

PRIMARY INSURANCE: Is patient the insured: _____ Yes (leave blank) **_____ No** (complete below)

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

Insured's Address: _____ Zip Code_____

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

Social Security #: _____-_____-_____ Insured's Relationship to Patient: _____Self _____Spouse _____Parent

SECONDARY INSURANCE – NOTE: If no secondary insurance, leave blank.

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

Insured's Address: _____ Zip Code_____

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

Social Security #: _____-_____-_____ Insured's Relationship to Patient: _____Self _____Spouse _____Parent

_____ I authorize Alaska Family Sonograms, Inc. (AFS) to release information required to secure the payment of benefits. I hereby authorize payment directly to Alaska Family Sonograms, Inc. of all insurance benefits otherwise payable to me for the services rendered. I authorize the use of my signature on all insurance submissions.

_____ 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.

_____ A late fee of $25.00 may be applied to my account if it becomes over 45 days delinquent.

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

_____ I authorize AFS to text me an appointment reminder.

_____ I authorize AFS to leave a brief message on my home, cell or work number voice mail unless noted otherwise below:

_____

Signature of Responsible Party: _____ Date: _____/_____/_____