

Alpenglow Acupuncture, LLC

3343 Fairbanks St.
Anchorage, Alaska 99503
(907) 336-6692

PATIENT: _____ DOB: _____ Age: _____
Last Name First Name Initial

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Street Address: _____ City _____ State: _____ Zip: _____

E-Mail Address: _____ Social Security # _____

Occupation: _____

Employer _____

Sex: M F Marital Status: Single Married Partner Widow/er Separated Divorced

Partner's Name: _____

Responsible Party: _____ DOB: _____ SS# _____

Employer: _____ Home Phone: _____

Address: _____ Work Phone: _____

Primary Insurance: _____

Address: _____

Subscriber Name: _____ DOB: _____ SS# _____

Subscriber ID #: _____ Group #: _____

Secondary Insurance: _____

Address: _____

Subscriber Name: _____ DOB: _____ SS# _____

Subscriber ID #: _____ Group #: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Address: _____

Referred By: Friend/Co-worker _____ Relative _____ Other _____

Health Care Provider _____ Yellow Pages (which one) _____

Release, Assignment and Statement of Responsibility

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to the provider(s). I understand that I may revoke this consent at anytime in writing to this office. I further understand that I am responsible for payment for all products and services rendered to me or any patient for which I am the guarantor of payment.

X _____ Date

Notice of Privacy Practices

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge and agree that I have reviewed a copy of Alpenglow Acupuncture's Notice of Privacy Practices made available to me. I acknowledge that I may request a copy of the notice at any time.

X _____ Date