ANCHORAGE NEUROSURGICAL ASSOCIATES, INC.

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WELCOME & THANK YOU for choosing ANAI! Please complete this form. (PLEASE PRINT) All information will be strictly confidential.

Patient Name (Goes by)	Social Security #	Marital Status S M W D Sep	Sex M F	Birth Date	Age
Mailing Address	City & State	Zip Code		Home Phone #	
Street Address	City & State	Zip Code		Alternate Phone #	
Patient's Employer	Occupation (Indicate if Student)			Business Phone #	
Employer's Street Address	City & State			Zip Code	
Spouse or Parent's Name	Social Security #	Relationship			
Spouse or Parent's Street Address	City & State	Zip Code		Contact Phone #	
Spouse or Parent's Employer	Occupation (Indicate if Student)			Business Phone #	
Employer's Street Address	City & State			Zip Code	
If Patient is a minor, who may authorize treatment?	Relationship			Contact Phone #	

Do you authorize release of your medical information to anyone besides you or your insurance carrier?

☐ **YES** (Please complete the reserve side with the person's name & relationship for each person you wish to designate.) ☐ **NO**

Do you have private telephone voice mail or an answering machine in your home? ÿ **YES** ÿ **NO**
If yes, may we leave messages from this office on that machine? ☐ **YES** ☐ **NO**
Is this related to a motor vehicle accident or any other third party liability claim? ÿ **YES** ÿ **NO**

Referring Physician	Mailing Address	Phone #

Do you have Medical Insurance? ☐ **NO, I intend to pay by:** ☐ **Check** ☐ **Cash** ☐ **Visa or MasterCard Card #:**

☐ **YES (Please complete the Insurance Section)**

Primary Insurance Carrier	Mailing Address	City & State	Zip Code
I.D. # or Social Security #	Group #	Insured Person	Birth Date
Secondary Insurance Carrier	Mailing Address	City & State	Zip Code
I.D. # or Social Security #	Group #	Insured Person	Birth Date

Worker's Compensation ☐ or Auto Insurance Carrier ☐ Name:	Claim #	Claims Adjuster
Date of Injury	Accident Description	Employer

Attorney's Name	Mailing Address	City & State	Zip Code

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare or other insurance company benefits be made on my behalf to ANCHORAGE NEUROSURGICAL ASSOCIATES, INC. for services furnished to me by that facility and the affiliated physician(s).

I authorize this office to release and disclosure to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.

_____ _____

Signature of Patient, Parent, Guardian, Personal or Legal Representative *Date*

***** PLEASE TURN OVER THE FORM AND COMPLETE THE OTHER SIDE! *****

HEALTH CARE PROFESSIONALS INFORMATION

Name:_____

Do you have any forms with you today that you will need completed? **Yes** **No**

Do you have a Nurse Case Manager to assist with your care? **Yes** **No** If so please provide their **Name**_____ Do we have your permission to discuss your care with them? **Yes** **No**

Primary Care Provider (First and Last Name): _____

Would you like a copy of your chart note from today to be sent to them for their records? **Yes** **No**

Other Health Care Providers: Would you like a copy of your chart note from today to be sent to them for their records? **Yes** **No**

If so, please list their names.

_____ _____

_____ _____

_____ _____

Person(s) who ANAI may discuss my medical information with:

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

Person(s) who ANAI may leave messages with regarding prescriptions and appointments:

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

Person(s) who may pick up my prescriptions at ANAI or the dispensing pharmacy:

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

Person(s) who may pick up my records, forms and information:

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

I acknowledge that Anchorage Neurosurgical Associates, Inc. may provide my medical information as noted to the person(s) I designated above.

_____ _____

Signature of Patient, Parent, Guardian, Personal or Legal Representative ***Date***