

REGISTRATION

(Please Print)

SITKA MEDICAL CENTER

700 Katlian St., Suite E
Sitka, AK 99835

Telephone: (907) 747-5861

Date Home Phone

Patient Last Name First Name Initial

Mailing Address

Street Address

City State Zip

Sex M F Age Birthdate Single Married Widowed Separated Divorced

Patient Employed By Patient Social Security #

Business Address

Occupation Business Phone

Spouse (or responsible party) Name Birthdate

Spouse (or responsible party) Social Security #

Business Name and Address Business Phone

Occupation

Do you have Medical Insurance? No Yes If yes,

Name of Primary Insurer

Contract # Group # Subscriber #

Name of Secondary Insurer (if any)

Contract # Group # Subscriber #

Medicare Medicaid Claim ID #

If Welfare, your number County of

In case of emergency, who should be notified?

How did you learn of our practice?

PATIENT ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with Name of Insurance Company and assign directly to Dr. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

MEDICARE AUTHORIZATION (only)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date