



Liberty Village, 9138 Arlon Street, Suite A-2  
Anchorage, AK 99507

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## PATIENT INFORMATION FORM

### PATIENT INFORMATION

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle name: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social security #: \_\_\_\_\_

Phone#(Home): \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Marital status:  Single  Married  Other

Employer: \_\_\_\_\_ Is your visit today due to an injury:  YES  NO

Preferred pharmacy: \_\_\_\_\_ Preferred Hospital \_\_\_\_\_

How did you hear about myHealth Clinic?: \_\_\_\_\_

### INSURANCE INFORMATION

Insurance company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

### PRIMARY CARD HOLDER INFORMATION

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Employer: \_\_\_\_\_

Card holder mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social security #: \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION

Insurance company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

### PRIMARY CARD HOLDER INFORMATION

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Employer: \_\_\_\_\_

Card holder mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social security #: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone#:(Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

May we release unlimited medical information to this person?:  YES  NO