Anchorage Foot and Ankle Clinic

1000 E Dimond Blvd
Suite 201
Anchorage, AK 99515-2029

Please verify the information is correct. Please make any necessary corrections, sign & date this form.

Patient Name: **Patient DOB:**
Patient Primary Address: _____
Patient Phone Number(s):

Email address:

Race: White, Black, Asian, Other (circle one) **Ethnicity:** Hispanic or Not-Hispanic (circle one)
Language: English, Spanish, Other (circle one)

Pharmacy for eRX Today (address & phone number): _____

Referral Source (Who may we thank?): _____

Insurance Information:

Primary Insurance: _____
Primary Subscriber ID/Group ID: _____/_____
Subscriber Name & DOB: _____

Secondary Insurance: _____
Secondary Subscriber ID/Group ID: _____/_____
Subscriber Name & DOB: _____

PLEASE PROVIDE YOUR INSURANCE CARD AND DRIVERS LICENSE SO WE CAN MAKE A COPY FOR YOUR FILE.

ASSIGNMENT OF BENEFITS: (ALLOWS US TO FILE FOR YOUR INSURANCE) I hereby assign all medical, to include major medical benefits to which I am entitled including Medicare and private insurance and any other health plans to: Anchorage Foot & Ankle Clinic, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize Anchorage Foot & Ankle Clinic, LLC to download my medication history and Rx benefits into my account from a Rx clearinghouse.

Signed:_____ Date: _____