Mat-Su Midwifery
& Family Health, Inc.

Patient Information

Full legal name_____

Date of Birth_____/___/_____

Social Securtiy # _____**Sex**____**Age**_____ **Today's Date**_____

Address_____
City_____**State**_____**Zipcode**_____ **Occupation**_____

Phone (H)_____**(C)**_____**Marital Status**_____

Ethnicity (optional)_____**Primary Language**_____

Email _____

If patient is a minor please complete the following:

Mother's Name_____Age_____

Phone (H)_____(C)_____(W)_____

Occupation_____ Employer Name_____
Marital Status_____ SSN_____

Primary party to contact for billing (circle) Yes No

Address (If different from
minor):_____
City_____State_____Zipcode_____

Father's Name_____Age_____

Phone (H)_____(C)_____(W)_____

Occupation_____ Employer Name_____
Marital Status_____ SSN _____

Primary party to contact for billing (circle) Yes No

Address (If different from
minor):_____

City_____State_____Zipcode_____

Insurance Information

Billing preference (circle one):

*Insurance *Personal Injury (auto) * Work Injury

* Medicaid (includes Denali KidCare) *Medicare *Self Pay

Please present photo ID and insurance information to front desk to be copied in addition to completing the following:

Name of Primary Insurance company:_____

Name of Policy Holder/Insured:_____

Relation to you (if NOT yourself)_____Insured Date of Birth_____

Insured SSN_____ Insured Employer name and location_____

Who may we thank for referring you to us today?_____

CONSENT FOR TREATMENT

I authorize the collective health care providers at Mat-Su Midwifery's Family Practice to render mutually agreed upon services as necessary for my care and/or my family.

Signature_____Date_____

FINANCIAL AGREEMENT

I understand that I am responsible for all fees regardless of insurance. I understand that fees will be generated for all services rendered if paying with insurance; I am responsible for furnishing the insurance information correctly to the office prior to treatment unless other arrangements have been made in advance. I hereby authorize Mat-Su Midwifery to furnish information to insurance carriers concerning my illness/injury and treatment and hereby assign all payments for medical services rendered to myself and my dependents.

Signature_____Date_____