

# Mat-Su Midwifery & Family Health, Inc.

## Patient Information

Full legal name \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_

Social Security # \_\_\_\_\_ 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 \_\_\_\_\_