FAIRBANKS PSYCHIATRIC AND NEUROLOGIAL CLINIC, P.C.

1919 Lathrop Street, Suite 220, Fairbanks, AK 99701 (907) 452-1739

REGISTRATION FORM

PATIENT INFORMATION

Legal Name Last First M.	Chart No. Office Use Only	Account No. Office Use Only
Sex / DOB / Age / Marital Status	Social Security No.	
Mailing Address	City	State / Zip
Home Phone No. ( )	Cell/Message Phone ( )	Business Phone No. ( )
Primary Care Physician	Referred by	Allergies
Employer (if student, indicate School)	Occupation	

RESPONSIBLE PARTY INFORMATION (if different than patient)

Responsible Party Name Last First M.	Social Security No.	Relationship
Mailing Address	City	State / Zip
Home Phone No. ( )	Cell/Message Phone ( )	Business Phone No. ( )
Employer	Occupation	

INSURANCE INFORMATION

Primary Insurance Company	Address	City	State	Zip
Policy No.	Group No.	Phone Number ( )		
Policy Holder Name Last First M.	DOB	Social Security No.	Relationship	
Secondary Insurance Company	Address	City	State	Zip
Policy No.	Group No.	Phone Number ( )		
Policy Holder Name Last First M.	DOB	Social Security No.	Relationship	
Medicare No. and Effective Date	Medicaid No.			
Workers' Compensation? ❑ Yes ❑ No	Motor Vehicle Accident (MVA)? ❑ Yes ❑ No	Date of Accident or Injury	Claim #	
Name and Address of Workers' Comp Carrier or Liable Party if MVA	Phone Number ( )			

I, the undersigned, authorize payment of medical benefits to Fairbanks Psychiatric and Neurological Clinic for any services furnished me. I also authorize you to release, to my insurance company or their agent, information concerning health care, advice, treatment or supplies provided me. This information will be used for the purpose of evaluating and administering claims of benefits. I consent to treatment or diagnostic testing as deemed necessary by the physician or his/her designate. I acknowledge full responsibility for the payment of such services regardless of insurance coverage. I acknowledge that cancellations, with less than 1 day notice, may be billed at full fee. I understand that insurance will not cover failed appointments. I request that payment of authorized Medicare benefits be made on my behalf to Fairbanks Psychiatric and Neurological Clinic for any services furnished me by their providers.

Patient/Guardian Signature ______________________________ Date ______________