Patient Demographic Information

Provider:	**Dr. Loretta Lee**	**Dr. Ulyana Stiassny**	**Dr. Young**
Local Pharmacy:		Mail Order Pharmacy:	
Patient: Last Name		First Name	Middle
Maiden:	Sex: M F	DOB:	SSN:
Race:		Ethnicity:	
Marital Status:		Language:	Religion:
Address:		City/State/Zip:	
Phone: Home	Work	Cell	
Email:			
Preferred Method of Communication (circle):	Home	Cell	Work Email
Emergency Contact #1:			
Name:			
Phone:			
Relationship:			
Emergency Contact #2:			
Name:			
Phone:			
Relationship:			
Primary Insurance*:*			
ID#		Group#	
Subscriber Name:		DOB:	
Relationship to Patient:		SSN:	
Secondary insurance:			
ID#		Group#	
Subscriber Name:		DOB:	
If Minor Parent/Legal Guardian:			
Date of Birth:		SSN:	
May we leave detailed messages about appointments and/or results?		**YES**	**NO**

Insurance authorization: I hereby assign Alaska Family Care Associates and Dr. Johnna Kohl all rights and interest to my medical reimbursement benefits. I authorize the release of any information to determine these benefits. This authorization shall remain in place unless otherwise revoked. I understand that I am responsible for providing accurate and up to date information. Any inaccurate or uncovered insurance information is directly responsible by the patient.

By signing this form, I hereby give Alaska Family Care Associates and Johnna Kohl, MD, LLC rights to use an electronic medical record system to retrieve prescription information that has been paid by insurance. Retrieving this information gives the providers complete information that will assist them in providing accurate prescribing information and any interactions that may occur.

Signature:	Date: