Alaska Hand-Elbow-Shoulder
4015 Lake Otis Parkway, Suite 201
Anchorage, AK 99508
Phone: (907)771-3500
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www.akhanddoc.com
Michael G. McNamara, MD Robert R. Thomas, PA-C Bethany A. Myers, PA-C

Submit by E-mail

Print Form

Patient Registration

Name: DOB: Sex: Marital Status:

Mailing Address:
Street City State Zip Code

Home#: Work#: Mobile#: SS#:

Occupation: Drivers License#: State:

Employer: Employer's Address:
Street City State Zip Code

Spouse/Parent/Responsible party: DOB: SS#:

Mailing Address:
Street City State Zip Code

Employer: Employer's Address:
Street City State Zip Code

Home#: Work#: Mobile#:

Insurance Information

Primary Insurance (or Workman's Comp carrier):

Subscriber name: DOB: SS#:

Subscriber ID# or Claim #: Group#:

Secondary Insurance (if applicable):

Subscriber Name: DOB: SS#:

Subscriber ID#: Group#:

Tertiary Insurance (if applicable):

Subscriber Name: DOB: SS#:

Subscriber ID#: Group#:

Emergency Contact: **Relationship:** **Phone#:**

Right to Privacy: May we share your health information with your spouse or a designated party? If yes, complete below:

Name: Relationship: Phone #:
First, Last, Middle Initial

Referred by: Hospital: Physician: Other:

Accident/Injury Information: Work/Auto?: What State?: Date of Injury: Is there an attorney?:

Attorney's Name: How did it happen?:

I verify that the above information is true and correct and that I will keep AkHES informed of any changes in the above.

Signature (responsible party): Date:

Signatures on this page expire one year from date signed. A new signature is required yearly.

By typing your name in this area you are stating the above information is true and correct to the best of your knowledge and this electronic form of signature will be treated the same as your original signature.