ALASKA RETINAL CONSULTANTS
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ANCHORAGE, ALASKA 99518
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Scott A Limstrom, MD Matthew G Guess, MD Chad Bouchard, DO

Demographics

Patient Information

Name: _____ **Gender:** _____

Date of Birth: ____ / ____ / ____ **Social Security Number:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Emergency Phone:** _____

Employer: _____ **Emergency Contact:** _____

Email: _____ **Referring Physician:** _____

Primary Care Physician: _____

Insurance Information

Primary: _____

Policy Number: _____ **Group Number:** _____

Policy Holder: _____ **Date of Birth:** ____ / ____ / ____

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent**

Secondary: _____

Policy Number: _____ **Group Number:** _____

Policy Holder: _____ **Date of Birth:** ____ / ____ / ____

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent**

Tertiary: _____

Policy Number: _____ **Group Number:** _____

Policy Holder: _____ **Date of Birth:** ____ / ____ / ____

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent**

Payment for services rendered by Alaska Retinal Consultants is your responsibility. We will be happy to submit claims to your insurance. If your insurance denies a claim for any reason you are responsible for payment to us.

I hereby authorize Alaska Retinal Consultants to release all information necessary to submit insurance claims. I assign all payments to Alaska Retinal Consultants.

Signature: _____ **Date:** _____ / _____ / _____

Medicare Lifetime Authorization

I request that payment under the medical insurance program be made either to me or to Alaska Retinal Consultants on any bills for services furnished to me during the effective period of this authorization and I authorize Alaska Retinal Consultants to release to the Social Security Administration or its intermediaries or carries any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Signature: _____ **Date:** _____ / _____ / _____