

Mark E. Richey, M.D., P.C.

Obstetrics & Gynecology

1200 Airport Heights Drive, Suite 205

Anchorage, AK 99508

Phone: (907) 272-4443 Fax: (907) 272-2262

Patient Registration Form

Patient Information

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Birthdate _____ Age _____

Single _____ Married _____ Divorced _____ Widowed _____

Social Security Number _____

Email _____

Employer _____

Office Phone _____ Occupation _____

Driver License No. _____

Emergency Contact Information

Person to contact if unable to reach patient (not living in your household)

Name _____

Relationship _____

Home Telephone _____

Office Telephone _____

REFERRED BY _____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, PPO plans and other health plans to Dr. Mark E. Richey. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information needed to secure the payment.

Signed _____

Date _____

Private insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

Spouse/Parent Information

Spouse/Parent Name _____

Home Address _____

City _____ State _____ Zip _____

Birthdate _____

Employer _____

Office Address _____

City _____ State _____ Zip _____

Office Phone _____ Occupation _____

Insurance Information

Primary Insurance _____

Insured _____

Policy or ID Number _____

Group Number _____

Secondary Insurance _____

Insured _____

Policy or ID Number _____

Group Number _____