Orthopaedic Research Clinic of Alaska, 2741 DeBarr Rd, Suite C-214, Anchorage, AK 99508, 907-644-6055

submit

When form is complete please click submit to send it to our office
Wait for the pop-up window to confirm that the form was sent before closing

1. PATIENT INFORMATION

Patient Last Name:_____ First Name:_____ M.I._____ DOB:_____ Age:_____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Race: PLEASE CHOOSE ONE Ethnicity: PLEASE CHOOSE ONE Preferred Language: PLEASE CHOOSE ONE

Mailing Address:_____ City/State/Zip:_____

Home Phone:_____ Cell/Other:_____ Current Employer:_____ Work Phone:_____

Social Security Number:_____ Email:_____ Driver's License #/State:_____

Referred By: Friend/Relative_____ Hospital_____ Physician_____ Insurance_____ Other_____

Is this a work-related injury? ☐ Yes ☐ No If yes, Date of Injury:_____ Employer @ time of injury:_____

Worker's Comp Insurance Name/Address:_____ Claim #:_____

Adjuster's Name and Phone Number:_____

2. RESPONSIBLE PARTY INFORMATION ☐ CHK HERE if Responsible Party is same as Patient, & skip to section 3

Last Name: _____ First Name:_____ DOB:_____

Mailing Address:_____ City/State/Zip:_____

Home Phone:_____ Work Phone:_____ Cell/Other:_____

Social Security Number:_____ Email:_____ Driver's License #/State:_____

Current Employer Name, City, State:_____

3. PRIMARY INSURANCE

Insurance Name:_____

Ins Address:_____

ID#:_____ Group #:_____

Subscriber's Name:_____

Subscriber's Phone #: _____

Subscriber's DOB:_____

Relationship to Patient:_____

SECONDARY INSURANCE

Insurance Name:_____

Ins Address:_____

ID#:_____ Group #:_____

Subscriber's Name:_____

Subscriber's Phone #: _____

Subscriber's DOB:_____

Relationship to Patient:_____

DO YOU HAVE MEDICARE? (please check yes or no) ☐ YES ☐ NO

_____ Initial **I understand that I am ultimately responsible for all charges incurred by me. I authorize my insurance company to pay Orthopaedic Research Clinic of Alaska (ORCA) for those charges I have not paid in full and which are filed by the ORCA on my behalf. If my insurance company pays ORCA a fee I have already paid, I understand that I will be promptly reimbursed.**

_____ Initial **I authorize ORCA to release any medical information required by my insurance company or workers compensation carrier for the processing of any medical claims filed on my behalf.**

_____ Initial **I acknowledge that I have received ORCA's *Notice of Privacy Practices*, which describes how medical information about me may be used and disclosed.**

_____ Initial **I give permission for ORCA to speak to the following people regarding my medical and/or billing information:**

_____

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**