



## Soaring Crane Natural Health Center

209 W Cedar Ave. Palmer, AK 99645. 907.745.3999. soaringcraneclinic.com

Date \_\_\_\_\_

Patient's Name, Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Responsible Party \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Social Security Number \_\_\_\_\_ Email \_\_\_\_\_

Sex: M F Date of Birth \_\_\_\_\_ Education \_\_\_\_\_

Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_ Partnership \_\_\_\_\_

Live with: Spouse \_\_\_\_\_ Partner \_\_\_\_\_ Children \_\_\_\_\_ (# \_\_\_\_\_) Friends \_\_\_\_\_ Alone \_\_\_\_\_

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_ Retired \_\_\_\_\_

Employer \_\_\_\_\_ SSN \_\_\_\_\_

(Work Address) \_\_\_\_\_

Health Insurance co. name and address:

\_\_\_\_\_

Telephone # (\_\_\_\_) \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Employer \_\_\_\_\_

Identification/SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Has any other family member already been a patient at the clinic? \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

I hereby authorize insurance benefits to be paid directly to Soaring Crane Natural Health Center, LLC. I authorize the release of any information required to process this claim. I understand this is not a final bill; lab or other charges may be added at a later time if deemed necessary by the clinician. I will pay all charges in full if insurance does not pay within 60 days.

Date \_\_\_\_\_

Signature \_\_\_\_\_