615 E. 82nd Ave., Suite 302
Anchorage, Alaska 99518-3159
Phone: 907-302-5750
Fax: 1-855-556-6673

MARISA BUNE, MSN, APRN, NP-C, CCRN-K ADRIENNE JOHNSON, MSN, ANP, FNP-BC

Patient Information

Full Name: ____ Birthdate: _____/_____/_____
Mailing Address: ____ Cell: _______________________
City/State/Zip: ____ Home: _____________________
Email (for patient portal access): _____________________________ Work: _____________________
Employer: ____ Soc Sec #: - -
Occupation: ____
Marital Status: Single Married Separated Divorced Widowed

Preferred Pharmacy: ____
Other Physicians you see: ____
Preferred Laboratory: ____

Persons who are authorized access to your medical information (does not include other clinics):
Name: ____ Relationship: ______________________
Name: ____ Relationship: ______________________

Emergency Contact
Name: _______________________________________ Relationship to Patient: ____________________
Phone #'s: Home: ___________________ Cell: ___________________ Work: ___________________

Primary Insurance:
Insurance Company: ___________________________________ ID #: ___________________________
Policy Holder Name: ___________________________________ Group #: ________________________
Policy Holder Relationship: ____________________ Policy Holder Date of Birth: _____/_____/_____
Secondary Insurance:
Insurance Company: ___________________________________ ID #: ___________________________
Policy Holder Name: ___________________________________ Group #: ________________________
Policy Holder Relationship: ____________________ Policy Holder Date of Birth: _____/_____/_____

By signing below, I understand that I am ultimately responsible for any charges, regardless of insurance coverage. I will update this office on any changes in my contact or insurance information during the course of billing and treatment.
I authorize this practice to release any necessary information acquired in the course of my treatment to process insurance claims and authorize payment directly to the physician. Protected health information may be disclosed to another covered entity for select health care operations, such as: payment activities, treatment, quality assessment activities, and other purposes. I may request a copy of the Notice of Privacy Policy. I understand the organized health care arrangement has the right to change this notice at any time and I may obtain a current copy by contacting this office.

Signature: ____ **Date:** ______/_____/______