Doug A. Vermillion, MD, 2741 DeBarr Rd. Suite C-214, Anchorage, AK 99508, 907-644-6055

Patient Name:____ **DOB:**____________________ **Age:**________

Social Security #:________________ **Driver's License #/State:**________________ **Email:**________________________

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

Mailing Address:____ **City/State/Zip:**______________________

Home Phone:________________________ **Work Phone:**____________________ **Cell/Other:**______________________

Employer Name:____

Employer Phone:______________________ **Occupation:**____

Referred By: Friend/Relative______________ Hospital____________ Physician__________________ Other______________

Emergency Contact Name:__________________________________ **Relationship:**______________ **Phone:**____________

Is this a work-related injury? Yes / No **If yes, Date of Injury:**____________ **Employer @ time of injury:**______________

Worker's Comp Insurance Name/Address:____ **Claim #:**____________

Responsible Party *(if patient is under 18 years of age)*:____

DOB:__________________________________ **Social Security Number:**____

Mailing Address:____ **City/State/Zip:**______________________

Home Phone:________________________ **Work Phone:**____________________ **Cell/Other:**______________________

Employer Name:____

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name:______________________________	**Insurance Name:**__________________________________
ID#:____________________ **Group #:**____________	**ID#:**____________________ **Group #:**________________
Subscriber's Name:____________________________	**Subscriber's Name:**________________________________
Subscriber's Phone #: ___________________________	**Subscriber's Phone #:** _______________________________
Subscriber's DOB:_____________________________	**Subscriber's DOB:**_________________________________
Relationship to Patient:________________________	**Relationship to Patient:**____________________________
Employer:___________________________________	**Employer:**_______________________________________

______ Initial — **I understand that I am ultimately responsible for all charges incurred by me. I authorize my insurance company to pay Dr. Vermillion for those charges I have not paid in full and which are filed by the Dr. Vermillion on my behalf. If my insurance company pays Dr. Vermillion a fee I have already paid, I understand that I will be promptly reimbursed.**

______ Initial — **I authorize Dr. Vermillion 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 Dr. Vermillion's *Notice of Privacy Practices*, which describes how medical information about me may be used and disclosed.**

______ Initial — **I give permission for Dr. Vermillion to speak to the following people regarding my medical and/or billing information:**

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PATIENT/GUARDIAN SIGNATURE **DATE**