Office Use Only Account #_____

MARY ANN JACOB, MD

2841 DEBARR RD
ANCHORAGE, AK 99508

T 907-274-0274
F 907-274-7809

NEW PATIENT INFORMATION SHEET

Patient Information									
Last Name:				First Name:				MI:	
Birth Date:		Sex:	M	F	Social Security#				
Child Resides with (Circle one):	Both Parents		Mother		Father		Other:		
Home Phone:									
Mailing Address:									
City:			State:				Zip:		
Physical Address:									
City:			State:				Zip:		
EMAIL:									
Other Children in Household:									
1)Name:				2)Name:					
Birth Date:	Sex:	M	F	Birth Date:		Sex:	M	F	
3)Name:				4)Name:					
Birth Date:	Sex:	M	F	Birth Date:		Sex:	M	F	

Responsible Party:	Relation To Child:		
Last Name:	First Name:	MI:	
Birth Date:	Social Security #		
Mailing Address:			
City:	State:	ZIP:	
Home Phone:	Daytime Phone:	Other	
EMAIL:			

Other Legal Guardian:	Relation To Child:		
Last Name:	First Name:	MI:	
Birth Date:	Social Security #		
Mailing Address:			
City:	State:	ZIP:	
Home Phone:	Daytime Phone:	Other	
EMAIL:			

Emergency Contact:			
Last Name:	First Name:		
Birth Date:	Social Security #		
Address:			
City:	State:	ZIP:	
Home Phone:	Daytime Phone:	Other	

Pharmacy Information:
(Please indicate the pharmacy at which you prefer to have your prescriptions filled.)

PLEASE COMPLETE PAGE TWO

NEW PATIENT INFORMATION SHEET - PAGE TWO

Primary Insurance Information		
Insurance Name:		
Insurance Address:		
Policy Holder:		
Birthdate:	Social Security #:	
Policy#:	Group#:	Copay Amount:
Employer:	Occupation:	Deductible Amount:

Secondary Insurance Information:		
Insurance Name:		
Insurance Address:		
Policy Holder:		
Birthdate:	Social Security #:	
Policy#:	Group#:	Copay Amount:
Employer:	Occupation:	Deductible Amount:

Medicaid or Denali Kid Care #:

Assignment and Release

I, the undersigned, certify that I have provided complete and accurate information on behalf of my family. I assign directly to Dr. Mary Ann Jacob all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Mary Ann Jacob to release all information necessary to secure payment of benefits. I authorize the use of my signature on all insurance submissions whether manual or electronic.

Responsible Party Signature: **Date:**

HIPPA Privacy Acknowledgement:

I have received and been give the opportunity to review the Notice of Privacy Practices for Dr. Mary Ann Jacob.

Responsible Party Signature: **Date:**