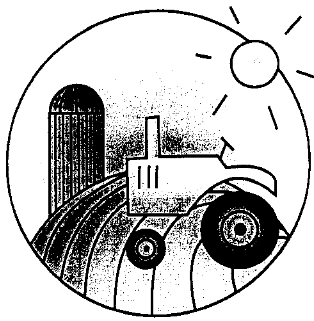

Office Use Only-2006 Account #_______________

MARY ANN JACOB, M.D.
2841 DeBarr Road, Suite #45
Anchorage, Alaska 99508
Telephone: (907) 274-0274
Fax: (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: **Birth Date:** **Sex: M F**	**2.) Name:** **Birth Date:** **Sex: M F**
3.) Name: **Birth Date:** **Sex: M F**	**4.) Name:** **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:**

Address:

City: **State:** **Zip:**

Home Phone: **Daytime Phone:** **Other:**

Pharmacy Information
(Please indicate which pharmacy 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:**	**Deductable Amount:**

Secondary Insurance Information		
Insurance Name:		
Insurance Address:		
Policy Holder:		
Birthdate:	**Social Security#:**	
Policy#:	**Group#:**	**CoPay Amount:**
Employer:	**Occupation:**	**Deductable 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 given the opportunity to review the Notice of Privacy Practices for Dr. Mary Ann Jacob.

Responsible Party Signature: **Date:**