In order to serve you properly, please provide the following information. All information is strictly confidential.

PATIENT INFORMATION: Female Male

Name :First:_____________________________ Last:_____________________________ Middle:__________ Birth Date ____/____/______

Social Security Number _____-_____-________ Mairtal Status S M D W

PHONE NUMBERS

Mailing Address:____ Home________________

Physical Address:____ Work________________

Employer____ Occupation______________________ Cell____________________

Employer Address____ Email______________________________

PERSON ACCOMPANYING A CHILD/Relationship to Patient: Mother Father other:_________________ **PHONE NUMBERS**

Name: First:__________________ Last:_________________ Address_______________________________ Home________________

Social Security Number_____-_____-________ Birth Date____/____/______ Work_________________

Employer____ Occupation_____________________ Cell__________________

PRIMARY INSURANCE

Insurance Co. Name____ ID #_________________________ Group #_________________

Insured's Name____ Relationship to Patient__________________________

Insured's Address: ____

Insured's Social Security Number______-_____-________ Insured's Birth Date____/____/______

SECONDARY INSURANCE

Insurance Co. Name____ ID #__________________________ Group #_________________

Insured's Name____ Relationship to Patient__________________________

Insured's Address: ____

Insured's Social Security Number _____-_____-_______ Insaured's Birth Date____/____/______

TERTIARY INSURANCE

Insurance Co. Name____ ID #__________________________ Group #_________________

Insured's Name____ Relationship to Patient__________________________

Insured's Social Security Number______-_____-_______ Insured's Birth Date____/____/______

I authorize my insurance company to issue the medical benefits of my plan directly to Aurora ENT, Dr. Totten, for services rendered to me. I understand and agree that if insurance does not cover services I am ultimately responsible for all charges. I also authorize the release of all information to my insurance company regarding my treatment, the diagnosis, or my condition that will aid in payment.

Patient/Responsible Party Signature____ **Print Name**________________________________

Date____/____/______

Aurora ENT, LLC Dr. Mary Totten 907-277-6673/Fax: 907-277-6695

I understand that the person listed below will be given any information regarding my treatment, diagnosis, condition, and financial information.

EMERGENCY CONTACT INFORMATION:

Relationship to Patient: Spouse Mother Father other:_________________ **PHONE NUMBERS**

Name: First:__________________Last:_________________Address______________________________ Home________________

Employer____Occupation____________________ Work_________________

Cell__________________

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I ______________________________ have read, and fully understand, the privacy practice policy of Aurora ENT, LLC. I have been given the chance to ask any questions regarding all information in the privacy practice policy handout which was offered to me at the time of my first appointment.

Signature:____ Date:___________________

AURORA ENT, LLC
Dr. Mary C. Totten, M.D.
3340 Providence Dr. Ste 461 Anchorage, AK 99508
Phone: (907) 277-6673 Fax; (907) 277-6695
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