Talkeetna Clinic
Mile 4.4
Talkeetna Spur Rd.
(907) 733-2273
HC 89 Box 8190
Talkeetna, AK 99676

Willow Clinic
24091
Long Lake Rd.
(907) 495-4100
PO Box 1049
Willow AK 99688

Monday – Friday
Fax: (907) 733-1735
www.sunshineclinic.org

Please review and update the information below to the best of your ability.

CURRENT PATIENT INFORMATION

Last Name: _____
First Name: _____
Middle Name: _____
Address: _____
City: _____ State: _____
Zip: _____
Home Phone: _____
Mobile Phone: _____
Sex: **( )Male ( )Female**
Date of Birth: _____
Social Security No.: _____
Patient email: _____
Required by government mandate [although you may refuse]:
Language: _____
Race: **( )American Indian or Alaska Native ( )Asian ( )European ( )Native Hawaiian or Pacific Islander ( )White**
Ethnicity: **( )Hispanic or Latino ( )Non-Hispanic or Latino**
Marital Status: **( )Single ( )Married ( )Divorced**
Gender Identity: _____

Guarantor Information (to whom statements are sent)

Name:
Address: _____
City/State/Zip**:** _____
Relationship to patient: _____
Date of Birth: _____
Social Security No.: _____
Phone: ( ) _____- _____

Emergency Contact Information

Name: _____
Relationship: _____
Phone: _____
Mobile Phone:( ) _____- _____

Employer information

Employer: _____
Address: _____
Phone: _____

Other

Patient Referred by:_____

Primary Care Provider: _____

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name: _____

Phone: _____

Primary Insurance Information

Insurance Plan Name: _____
Insured ID: _____
Insured Last Name: _____
Insured First Name: _____
Address: _____
City: _____ State: _____Zip: _____
Date of Birth: _____
Sex (please circle): **M** or **F**
Patient's relationship to policy holder: _____

Secondary Insurance Information

Insurance Plan Name: _____
Insured ID: _____
Insured Last Name: _____
Insured First Name: _____
Address: _____
City: _____State: _____Zip: _____
Date of Birth: _____
Sex (please circle): M or F
Patient's relationship to policy holder: _____

To the best of my knowledge the above information is complete and accurate.

Signed_____**Date:**_____

SUNSHINE
COMMUNITY HEALTH CENTER

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Sunshine Community Health Center • Patient Acknowledgments and Authorizations

NAME (print): _____ DOB: _____
Contact Number: _____

I authorize Sunshine Community Health Center (SCHC) to provide me and/or my family member with medical/behavioral/dental care. I acknowledge that it's my responsibility to pay for care according to the fees established, whether or not these fees are paid by insurance. I authorize the release of my protected health information necessary to process insurance claims. I assign directly to SCHC all insurance benefits, if any, otherwise payable to me for services rendered. If my provider prescribes controlled substances, I give SCHC permission to gather information regarding controlled substance prescriptions, past and present, from other providers and pharmacies.

☐ **I understand the HIPAA/Privacy Policy for SUNSHINE COMMUNITY HEALTH CENTER INCORPORATED**

☐ **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

☐ **I authorize SUNSHINE COMMUNITY HEALTH CENTER INCORPORATED to release the medical information required to process my claim**

☐ **I have read and understand the Financial Policy for SUNSHINE COMMUNITY HEALTH CENTER INCORPORATED**

☐ **I authorize SUNSHINE COMMUNITY HEALTH CENTER INCORPORATED to obtain/have access to my medication history**

- **Signature:** _____

Date:_____