

# Family Practice Physicians

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## NEW PATIENT / UPDATE INFORMATION

**\*\* Confidential Information to be filed in patient's chart \*\***

Patient Name: \_\_\_\_\_

Patient Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Patient Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  Male  Female

Is the patient a minor? Yes  No

If yes, please provide information for parent or guardian:

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address same as patient? Yes  No

If no, please provide address for parent or guardian: \_\_\_\_\_

Who may we contact in case of an emergency? \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## INSURANCE INFORMATION

*(Please provide insurance card(s) to receptionist)*

1. Primary Insurance Company Name: \_\_\_\_\_

Insurance holder: \_\_\_\_\_

Relationship to patient : \_\_\_\_\_ Date of Birth : \_\_\_\_\_

2. Secondary Insurance Company Name: \_\_\_\_\_

Insurance holder: \_\_\_\_\_

Relationship to patient : \_\_\_\_\_ Date of Birth : \_\_\_\_\_

*Thank you very much for your cooperation!!!*