John Boston D.O. • Amy Johnson, ANP Internal Medicine
950 E. Bogard Rd., Ste. 228 Wasilla, AK 99654
Phone (907) 376-8938 Fax (907) 376-8939

Patient Registration Form

Date:

Name: _____ Maiden Name: _____
(First) (MI) (Last)

SSN: _____Birth Date: _____ Age: _____

Marital Status: _____ Sex: ☐M or ☐F

Race:_____ Ethnicity:_____ Language:_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Email: _____

Primary Contact Method (check one): ☐Cell Phone ☐ Email ☐ Home Phone ☐ Patient Portal ☐ Postal ☐ Work Phone

Secondary Contact Method (check one): ☐Cell Phone ☐ Email ☐ Home Phone ☐ Patient Portal ☐ Postal ☐ Work Phone

Employed By: _____ Referred By: _____

Spouse's Name: _____

Emergency Contact/Relationship: _____/_____

Home Phone: _____ Cell Phone: _____

Insurance Information (Please fill out)

Name of Insurance Company (Primary): _____ Insurance ID Number(s):_____

Person Responsible for Account: _____Subscriber's Date of Birth: _____
(Last) (First) (MI)

Name of Insurance Company (Secondary): _____ Insurance ID Number(s):_____

Person Responsible for Account: _____Subscriber's Date of Birth: _____
(Last) (First) (MI)

Please Provide a Copy of your Insurance Card(s) to the Front Desk

*Note: We do NOT bill Tertiary insurance.

Assignment and Release

The above information is true to the best of my knowledge, I authorize my insurance benefits be paid directly to the physician. I also authorize Dr. John Boston D.O., or insurance company to release any information required to process my claims.

I AM AWARE THAT DELINQUENT ACCOUNTS TURNED OVER TO A COLLECTION AGENCY WILL INCUR A 25% CHARGE.

Patient Signature: **Date:**