Pioneer GI Clinic, APC
1200 Airport Heights Dr. Ste 210 Building E
Anchorage, AK 99508

www.pioneergiclinic.com

Phone: 907 562-6001
Fax: 907 562-6002
office@pioneergiclinic.com

Patient Paperwork

Legal Last Name	Legal First Name		Middle Initial	Preferred Name
SSN	Date of Birth		Gender: ❑ Male ❑ Female ❑Other:_____	
Address			Home Number	
City	State	Zip	Cell Number	

What is Your Race? (Check one or more)
❑ Alaska Native ❑ Black/African American ❑ White ❑ Asian ❑ Hispanic/Latino
❑ Native American ❑ Hawaiian/Pacific Islander ❑ Unknown ❑ Other_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Partner ❑ Widow

Primary Care Provider	Referring Physician	
Preferred Pharmacy	Preferred Pharmacy Address	
Emergency Contact Name	Relationship	Phone #
Employer	Occupation	Employer Phone #

Patient Portal

Pioneer GI Clinic has a secure and confidential Internet-based portal to enhance communication with our clients. By providing your email, you are consenting to receive email communications from Pioneer GI Clinic.

Would you like to be web-enabled? ❑ Yes ❑ No Email Address_____

Primary Insurance

Primary Insurance Name	ID Number	Group Number
Policy Holder's Name and DOB	Relationship of Policy Holder to you	

Secondary Insurance

Secondary Insurance Name	ID Number	Group Number
Policy Holder's Name and DOB	Relationship of Policy Holder to you	

Tertiary Insurance

Tertiary Insurance Name	ID Number	Group Number
Policy Holder's Name and DOB	Relationship of Policy Holder to you	

Pioneer GI Clinic, APC
1200 Airport Heights Dr. Ste 210 Building E
Anchorage, AK 99508

www.pioneergiclinic.com

Phone: 907 562-6001
Fax: 907 562-6002
office@pioneergiclinic.com

Privacy Agreement

Name: _____ **DOB:** _____

Power of Attorney
Definition: A legal document giving a person the power to make decisions for another person (e.g., medical decisions, financial decisions)
Do you have a power of attorney on file? ❑ Yes ❑ No
Name of Person who holds the Power of Attorney: _____ Phone: _____

Right to Privacy	
We understand you may have concerned relatives and we respect your right to privacy regarding medical information. Please list names of individuals with whom we may share information without additional written consent.	
Name	Relationship
Name	Relationship

Authorization
❑ I authorize Pioneer GI Clinic to administer medical treatment and access my electronic prescription records for continued care and further treatment.
❑ The following facilities (Surgery Center of Anchorage, South Anchorage Surgery Center, Providence Alaska Medical Center, and/or Alaska Regional Hospital) are hereby authorized to review/access my Pioneer GI Clinic medical record for, treatment and diagnostic record for coordination of care.
★ **I acknowledge and agree to the terms above:**
Patient Signature: _____ **Date:** _____