Katy Sheridan MD
Kali Saxton-Shaw PA-C
154 W Marydale Ave
Soldotna, AK 99669

Patient Information:

_____
Patient Name (Above) Date of Birth Sex (M/F)

_____
Mailing Address (Above)

Marital Status _____ Driver's License # _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Email Address:
_____
Email is not through a secure site. If information is urgent please call do not email.

Race: _____ Ethnicity: Hispanic/ Non Hispanic Declined to Answer: _____

Financially Responsible / Primary Insured Information:

_____
Spouse, Parent, or Other (Please Circle One) Date of Birth S.S.N.

Mailing Address:
_____

_____
Home Phone Cell Phone Work Phone

Please present insurance cards and/or Medicaid card or stickers to the receptionist.

I authorize the release of any medical information necessary to process my claims. **Yes or No** (Please Circle One)

I have provided information that is accurate to the best of my knowledge. I understand that my bill is due at the time of service unless prior financial arrangements have been made.

_____
Signature of Responsible Party Date