Resolution Services
Office of Vivian Patton
401 E. Northern Lights Blvd. Suite 205 Anchorage, AK 99503
Phone# (907)770-7769 Fax# (907)770-7634

Name: _____ **Birth Date:** ____/____/____
Address: _____ **SSN:** _____
_____ **Male**_____ **Female**_____

E-Mail: _____ **Phone: (H)**_____
Phone: (C)_____

Employer/School: _____ Length of current employment: _____
Address: _____ Phone #:_____
Occupation: _____

Emergency Contact Name: _____ **Relationship:**_____
Phone Number: _____

Who referred you to the clinic? _____
Have you been in treatment before? If so, where and when? _____
Current reason for seeking treatment: ____ AODA ____ Interpersonal
____ Academic/Career ____ Court Ordered

Relationship Status: _____ Married _____ Yrs _____ Never married _____ Separated
_____ Committed Relationship _____ Divorced _____ Yrs _____ Widowed _____ Yrs
Children: (Names and Ages): _____
_____

Do you have private insurance? Y_____ N_____

Insurance/Billing Information

Primary Insurance Data:
Insurance Company:_____
ID # _____Group # _____
Group Name: _____ Effective Date:_____ Co-pay amount:_____
Insurance Verification Phone:_____
Policy Holder Name:_____ Date of Birth: _____
Social Security #:_____ Relationship to you:_____
Address: _____ Employer:_____

~Please provide your insurance card upon intake. Co-payments and deductibles are the patients' responsibility. ALL information must be filled in under the insurance information section. Missing information can delay claim processing and/or be denied by the insurance company. Any bills that remain outstanding due to missing information will become the patients' responsibility to pay.~

Please print legal name clearly: _____
Signature: _____