

PATIENT REGISTRATION WORKSHEET

Check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Alaska Native (01) | <input type="checkbox"/> US Citizen | <input type="checkbox"/> Alaska Resident |
| <input type="checkbox"/> Lower 48 American Indian (01) | <input type="checkbox"/> Civil Services PHS Employee (02) | <input type="checkbox"/> Locum/Volunteer (33) |
| | <input type="checkbox"/> Commissioned Officer (03) or Dependent (04) | <input type="checkbox"/> Medical Student/Resident (08) |
| | <input type="checkbox"/> SEARHC Employee or Dependent (08/33) | <input type="checkbox"/> Non-Native OB (32)/Family Member(18) |

PATIENT INFORMATION:

LAST NAME FIRST M.I. DATE OF BIRTH SOCIAL SECURITY NUMBER

GENDER: MALE FEMALE MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOW VETERAN: YES NO

CITY AND STATE OF BIRTH: _____ OTHER NAMES USED: _____

CURRENT COMMUNITY: _____ (DATE MOVED TO CURRENT COMMUNITY): _____

MAILING ADDRESS: _____
PO BOX/STREET CITY STATE ZIP CODE

HOME/CELL PHONE: _____ MESSAGE PHONE: _____

PATIENT'S EMPLOYER: _____ WORK PHONE: _____

SPOUSE'S EMPLOYER: _____ WORK PHONE: _____

PLEASE COMPLETE FOR PATIENTS 0-18 YEARS OF AGE:

FATHER'S NAME: _____ CITY AND STATE OF BIRTH: _____

EMPLOYER: _____ WORK PHONE: _____

MOTHER'S MAIDEN NAME: _____ CITY AND STATE OF BIRTH: _____

EMPLOYER: _____ WORK PHONE: _____

INSURANCE INFORMATION FOR BILLING ARE YOU COVERED BY:

MEDICARE YES NO If YES, ID# _____ COPY

MEDICAID YES NO If YES, ID# _____ COPY

DENALI KIDCARE YES NO If YES, ID# _____ COPY

VETERANS AFFAIRS YES NO If YES, ID# _____ COPY

OTHER INSURANCE COMPANY: _____ Effective Date : _____ Policy# _____

PRIMARY POLICY HOLDER'S NAME _____ DATE OF BIRTH _____ GROUP# _____

DEPENDENT(S) NAME _____ DATE(S) OF BIRTH _____

PLEASE LIST ADDITIONAL INSURANCE COVERAGE ON BACK OF THIS FORM

FIRST PERSON TO CONTACT IN THE EVENT OF A MEDICAL EMERGENCY:

NAME: _____ PHONE NUMBER _____ RELATIONSHIP _____

ADDRESS: _____
PO BOX/STREET CITY STATE ZIP CODE

NEXT OF KIN TO GIVE CONSENT FOR TREATMENT & SIGN DOCUMENTS WHEN PATIENT NOT ABLE TO:

NAME: _____ PHONE NUMBER _____ RELATIONSHIP _____

ADDRESS: _____
PO BOX/STREET CITY STATE ZIP CODE

FOR OFFICE USE ONLY:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> PICTURE IDENTIFICATION | <input type="checkbox"/> NATIVE ELIGIBILITY DOCUMENT | <input type="checkbox"/> PROOF OF PREGNANCY | <input type="checkbox"/> MSP |
| <input type="checkbox"/> BIRTH CERTIFICATE | <input type="checkbox"/> MARRIAGE CERTIFICATE | <input type="checkbox"/> MILITARY ID | <input type="checkbox"/> AUTHORIZATION TO TREAT/PROMISE TO PAY |
| <input type="checkbox"/> 120 LETTER | <input type="checkbox"/> STATEMENT OF PATERNITY | <input type="checkbox"/> NOTICE OF PRIVACY | <input type="checkbox"/> AR REFERRAL |