

Patient Registration Worksheet/Form (PRW)

OFFICE USE ONLY	
<input type="checkbox"/> New <input type="checkbox"/> Established/Update <input type="checkbox"/> Activate	<input type="checkbox"/> Pending <input type="checkbox"/> Ineligible <input type="checkbox"/> Direct <input type="checkbox"/> CHS/Direct

Please print, or check the correct box.

PATIENT INFORMATION/PERMANENT ADDRESS

Last Name: _____ First Name: _____ Middle Name: _____ Suffix: _____
 Address 1: _____ DOB: _____ Age: _____
 Address 2: _____ SSN: _____ Gender: _____
 City: _____ St: _____ Zip: _____ Home Phone: _____
 Message/Local Phone: _____ Work Phone: _____
 Current Community: _____
Marital Status: Single Married Divorced Separated Widowed

Is the patient:

Aleut Eskimo Alaskan Indian (Native) _____ American Indian _____

What Corporation/Tribal Membership?:

Blood Quantum: (How much Alaskan Native/American Indian are you?)

1/8 1/4 1/2 3/4 Full Other _____

Race/Ethnicity/Heritage

Asian Black/African American Hispanic Other
 Native Hawaiian Other Pacific Islander White

Commissioned Officer or Dependent of Commissioned Officer Civil Service PHS Employee
 Other (Medical Student, Volunteer)

Employment Status: (choose one)

Full-Time or Part-Time Student Full-Time Employed Part-time Employed Unemployed Self Employed Retired Active Military

Employer: _____ **Occupation:** _____
Address: _____ **City:** _____ **St:** _____ **Zip:** _____
Phone: _____ **Type of Business:** _____

Migrant/Seasonal

Yes No
 (If yes, provide temporary address.)

Homeless

Yes No

Interpreter Needed

Yes No
 (If yes, alert Cust. Svc. if available and requested.)

Other Information - Legal : (check all that apply)

Tribal Adoption Yes No Guardianship Yes No Durable Power of Attorney Yes No
 Foster Parent Yes No Court Order Yes No Other _____

GUARANTOR INFORMATION (Makes decisions for the patient)

Relationship to Patient: _____

Last Name: _____ First Name: _____ MI: _____
 Address: _____ DOB: _____ Age: _____
 _____ SSN: _____ Gender: _____
 City: _____ St: _____ Zip: _____ Home Phone: _____
 Employer: _____ Work Phone: _____

Patient Name:
MR:

PLEASE COMPLETE BOTH PAGES OF THIS FORM

Revised 11/7/06
 Approved HRC 03/02/07
 Approved RRW 11/06

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PATIENT INFORMATION/PERMANENT ADDRESS

Last Name: _____	First Name: _____	Middle Name: _____	Suffix: _____
#1 PRIMARY INSURANCE INFORMATION (Please provide clerk the insurance card.)			
Ins. Company: _____		Phone: _____	
Address: _____		City: _____	St: _____ Zip: _____
Policy Holder: _____		Relation to Patient: _____	
Policy Holder DOB: _____	Policy Holder Gender: _____	Policy Holder Employer: _____	
Policy #: _____	Group #: _____	Policyholder SSN: _____	
Policy Holder Address: _____		Phone: _____	
Additional Information: _____			

#2 SECONDARY INSURANCE INFORMATION (Please provide clerk the insurance card.)			
Ins. Company: _____		Phone: _____	
Address: _____		City: _____	St: _____ Zip: _____
Policy Holder: _____		Relation to Patient: _____	
Policy Holder DOB: _____	Policy Holder Gender: _____	Policy Holder Employer: _____	
Policy #: _____	Group #: _____	Policyholder SSN: _____	
Policy Holder Address: _____		Phone: _____	
Additional Information: _____			

Does the patient have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes, provide clerk with your coupons.</small>	Does the patient have Denali Kidcare? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes, please provide clerk the card.</small>	Does the patient have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes, please provide clerk the card.</small>
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Is the patient a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes, provide clerk with your fee service card.</small>	Is this a service related injury and/or is it pre-authorized by VA? <input type="checkbox"/> Yes <input type="checkbox"/> No
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#1 EMERGENCY CONTACT/NEXT OF KIN		Relationship to Patient: _____	
Last Name: _____		First Name: _____ MI: _____	
Address: _____		DOB: _____ Age: _____	
City: _____ St: _____ Zip: _____		SSN: _____ Gender: _____	
Employer: _____		Home Phone: _____	
		Work Phone: _____	

#2 EMERGENCY CONTACT/NEXT OF KIN		Relationship to Patient: _____	
Last Name: _____		First Name: _____ MI: _____	
Address: _____		DOB: _____ Age: _____	
City: _____ St: _____ Zip: _____		SSN: _____ Gender: _____	
Employer: _____		Home Phone: _____	
		Work Phone: _____	

I understand that by coming to see a provider at ANMC and by cooperating with the requests and directions of its providers and staff, I am consenting to the care they provide unless I specifically object or otherwise decline one or more aspects of the care they offer. I understand that ANMC has a right to bill my insurer and any other third party who may be obliged to cover the costs of the services I receive. I hereby assign my rights to such claims to ANMC along with any benefits that would otherwise be payable to me. I also agree to assist ANMC pursue these claims and hereby authorize ANMC release medical information and take other steps that may be reasonably necessary to do so. I understand that I may be personally responsible for some financial costs in accordance with ANMC's policies and procedures (Who Must Pay).

Signature: _____

Date: _____

Patient Name:
MR:

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