Patient Registration Worksheet/Form (PRW)

OFFICE USE ONLY

☐ New ☐ Established/Update ☐ Activate

☐ Pending ☐ Ineligible ☐ Direct ☐ 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: _____

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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? ☐ Yes ☐ No
If yes, provide clerk with your coupons.

Does the patient have Denali Kidcare? ☐ Yes ☐ No
If yes, please provide clerk the card.

Does the patient have Medicare? ☐ Yes ☐ No
If yes, please provide clerk the card.

Is the patient a Veteran? ☐ Yes ☐ No If yes, provide clerk with your fee service card.

Is this a service related injury and/or is it pre-authorized by VA? ☐ Yes ☐ No

#1 EMERGENCY CONTACT/NEXT OF KIN Relationship to Patient:

Last Name: First Name: MI:

Address: DOB: Age:

SSN: Gender:

City: St: Zip: Home Phone:

Employer: Work Phone:

#2 EMERGENCY CONTACT/NEXT OF KIN Relationship to Patient:

Last Name: First Name: MI:

Address: DOB: Age:

SSN: Gender:

City: St: Zip: Home Phone:

Employer: 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:

PLEASE COMPLETE BOTH PAGES OF THIS FORM

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