Alaska Native Medical Center
Patient Registration Worksheet / PRW

Person Requesting New Chart_____ Organization or Location _____ Phone _____

PLEASE PRINT CLEARLY, ALL INFORMATION IS REQUIRED NEW CHART MRN_____

Last Name _____ First Name _____ M.I._____ Suffix _____ Gender ____
Mailing Address_____ Date of Birth_____ Social Security #_____
City_____ State_____ Zip _____ Phone Number_(_____)_____
PREFERED CONTACT METHOD _____ Patient Portal _____ Phone _____ Letter _____ No Preference
Is this Patient AK Native or American Indian? ☐ Yes ☐ No Hispanic or Latino? ☐ Yes ☐ No
Tribe: _____ Are you Homeless? ☐ Yes ☐ No
Race/Heritage: ☐Asian ☐African American ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other
Do you have Advanced Directives? ☐ Yes ☐ No Is there a copy on file with A.N.M.C.? ☐ Yes ☐ No
Do you have a designated Power of Attorney or Legal Guardian? ☐Yes ☐No Do we have a copy on file? ☐Yes ☐No
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner

Preferred Language: _____ Do you need an Interpreter? ☐ Yes ☐ No
Have You Served in The Armed Forces? ☐ Yes ☐ No Branch? _____ V.A. Benefits? ☐ Yes ☐ No
EMPLOYMENT ☐ Full Time Employed ☐ Part Time Employed ☐ Unemployed ☐ Full Time or Part Time Student
☐ Self Employed _____ ☐Retired Date of Retirement_____
Employer Name_____

GUARANTOR INFORMATION (IF PATIENT IS A MINOR, LIST WHO IS RESPONSIBLE FOR THIS PATIENT)

Relationship to Patient_____ Social Security #_____ Gender_____
Last Name: _____ First Name: _____ MI:____ D.O.B. _____
Mailing Add. _____ City: _____ State: _____ Zip Code: _____
Home Phone_____ Cell Phone _____ Employer _____

OFFICE USE ONLY

ELIGIBILITY☐ PENDING ☐ INELIGIBLE ☐ DIRECT ONLY ☐ PRC AND DIRECT ☐
VA CONTRACT ☐ DEPT OF DEFENSE ☐ EMPLOYEE ☐ EMPLOYEE HEALTH ONLY ☐
COMMISSIONED OFFICER☐ APU STUDENT ☐
DEPENDENT OF COMMISSIONED OFFICER ☐ NON BEN / OTHER_____

Patient Identification Label

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ADDITIONAL INFORMATION

Does this patient have Medicaid? ☐ Yes ☐ No Denali Kid Care? ☐ Yes ☐ No Medicare? ☐ Yes ☐ No

If IHS only, please refer to Health Benefits Specialist

PRIMARY INSURANCE INFORMATION Scan Both Sides of Insurance Card

Ins. Company: _____ Policy Holder: _____ Policy Holder D.O.B. _____

Policy Number: _____Group Number: _____ Policy Holder Phone: _____

Policy Holder Employer:_____ Policy Holder Social Security #_____

Relationship to Patient_____

SECONDARY INSURANCE INFORMATION Scan Both Sides of Insurance Card

Ins. Company: _____ Policy Holder: _____ Policy Holder D.O.B. _____

Policy Number: _____Group Number: _____ Policy Holder Phone: _____

Policy Holder Employer:_____ Policy Holder Social Security #_____

Relationship to Patient_____

NEXT OF KIN Relationship to Patient_____

Last Name_____ First Name:_____ Cell Phone: (___)_____

Home Phone: (___)_____ Work Phone: (___)_____

EMERGENCY CONTACT

Relationship to Patient_____

Last Name_____ First Name:_____ Cell Phone: (___)_____

Home Phone: (___)_____ Work Phone: (___)_____

ADDITIONAL CONTACT Relationship to Patient_____

Last Name_____ First Name:_____ Cell Phone: (___)_____

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, and that federal Privacy law permits ANMC to release certain health information to those insurers I have identified as being responsible for payment. I hereby assign my rights to such claims to ANMC along with any benefits that I would otherwise be payable to me. I also agree to assist ANMC pursue these claims and hereby authorize ANMC to release medical information and take other steps that may be reasonable 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:_____

PRINTED NAME:_____ MRN:_____

Patient Identification Label