Patient Registration Worksheet/Form (PRW)

OFFICE USE ONLY	
	☐ Pending
☐ New	☐ Ineligible
☐ Established/Update	☐ Direct
☐ Activate	☐ 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	**Homeless**	**Interpreter Needed**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(If yes, provide temporary address.)		(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:

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:

#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?	Does the patient have Denali Kidcare?	Does the patient have Medicare?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, provide clerk with your coupons.	If yes, please provide clerk the card.	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:

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

PLEASE COMPLETE BOTH PAGES OF THIS FORM