ALASKA REGIONAL
Senior Health Clinic
Serving Alaska's Medicare Beneficiaries

PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please Print)

□Mr. □Mrs. □Ms. □Jr. □Sr. □Other _____

Patient's Name (Last) _____ (First) _____ (MI) ____

Marital Status □ Married □ Single □ Divorced □ Widowed □ Legally Separated □ Other

Social Security Number _____-_____ -_____ □Female □Male Date of Birth _____/_____ /_____

Phone Numbers Home _____ Work_____ Cell _____

Contact Preference: □Home □Cell □Other _____ Automated appointment reminders: □ Yes □ No

Address _____

Street City State Zip

Do you reside in an assisted living facility? □Yes □No

If yes, please provide facility name and phone #: _____

E-Mail Address for Patient Portal:_____

Language: _____ Race: _____ Ethnicity: _____

Employment Status □Employed □Retired □Self-Employed □Unemployed

Employer _____ Employer Phone Number _____

Emergency Contact Name _____Phone Number _____

Relationship to Patient _____

RESPONSIBLE PARTY INFORMATION

Do you have a Power of Attorney or Legal Guardian? □ Yes □ No

If yes, please provide name and phone #:_____

*Supporting documents are required

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insured Date of Birth _____ /_____ /_____

Insurance Company/Phone Number _____ (_____)_____

Subscriber ID (Policy Number) _____ Group ID _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insured Date of Birth _____ /_____ /_____

Insurance Company/Phone Number _____ (_____)_____

Subscriber ID (Policy Number) _____ Group ID _____

PREFERRED PHARMACY

Name _____ Location _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ *Date* _____