# 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**
☐ 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
Foster Parent ☐ Yes ☐ No
Guardianship ☐ Yes ☐ No
Court Order ☐ Yes ☐ No
Durable Power of Attorney ☐ 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

# Patient Registration Worksheet/Form (PRW)

Please print, or check the correct box.

OFFICE USE ONLY

- ☐ New
- ☐ Established/Update
- ☐ Activate
- ☐ Pending
- ☐ Ineligible
- ☐ Direct
- ☐ CHS/Direct

**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