PATIENT REGISTRATION

Address: 155 Smith Way, Suite 102 Soldotna, AK 99669 | **Phone:** (907) 262-4989 | **FAX:** 907-206-7892

ID:_____ **CHART ID:**_____

First Name:		Last Name:		Middle Initial:			
Patient Is:	☐ Policy Holder ☐ Responsible Party		Preferred Name:				
Responsible Party (if someone other than the patient):							
First Name:		Last Name:		Middle Initial:			
Address:			Address 2:				
City,		State:		Zip:		Pager:	
Home Phone:		Work Phone:		Ext:		Cellular:	
Date of birth:		SSN:		Drivers Lic:			
☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder							

PATIENT INFORMATION

Address:			Address 2:				
City:		State:		Zip:		Pager:	
Home Phone:		Work Phone:		Ext:		Cellular:	
Sex: ☐ Male ☐ Female		**Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed					
Date of birth:		SSN:		Drivers Lic:			

EMPLOYER

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired				Student Status:		☐ Full Time ☐ Part Time	
Medicaid ID:			Pref. Dentist:				
Employer ID:			Pref. Pharmacy:				
Carrier ID:			Pref. Hyg:				
Emergency Contact:							

PRIMARY INSURANCE INFORMATION

Name of Insured:			Relationship to Insured Self:	☐ Self ☐ Spouse ☐ Child ☐ Other			
Insured SSN:			Insured Birth Date:			Group #:	
Employer:			Ins. Company:				
Address:			Address 2:				
Address 2:			Address 2:				
City:			City:				
State:		Zip	State:			Zip:	
Rem. Benefits:			Rem. Deduct:				

SECONDARY INSURANCE INFORMATION

Name of Insured:			Relationship to Insured	☐ Self ☐ Spouse ☐ Child ☐ Other			
Insured SSN:			Insured Birth Date:			Group #:	
Employer:			Ins. Company:				
Address:			Address:				
Address 2:			Address 2:				
City:			City:				
State:		Zip	State:			Zip:	