Patient Registration Worksheet/Form (PRW)

OFFICE USE ONLY

O Pending
O New
O Ineligible
O Established/Update
O Direct
O Activate
O 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: O Single O Married O Divorced O Separated O Widowed

Is the patient:

O Aleut O Eskimo O Alaskan Indian (Native) _____ O American Indian _____
What Corporation/Tribal Membership?: _____

Blood Quantum: (How much Alaskan Native/American Indian are you?)
O 1/8 O 1/4 O 1/2 O 3/4 O Full O Other _____

Race/Ethnicity/Heritage
O Asian O Black/African American O Hispanic O Other
O Native Hawaiian O Other Pacific Islander O White

O Commissioned Officer or O Dependent of Commissioned Officer O Civil Service PHS Employee
O Other (Medical Student, Volunteer)

Employment Status: (choose one)

O Full-Time or Part-Time Student O Full-Time Employed O Part-time Employed O Unemployed O Self Employed O Retired O Active Military

Employer: _____ Occupation: _____
Address: _____ City: _____ St: _____ Zip: _____
Phone _____ Type of Business: _____

Migrant/Seasonal
O Yes O No
(If yes, provide temporary address.)

Homeless
O Yes O No

Interpreter Needed
O Yes O No
(If yes, alert Cust. Svc. if available and requested.)

Other Information - Legal : (check all that apply)

Tribal Adoption O Yes O No | Guardianship O Yes O No | Durable Power of Attorney O Yes O No
Foster Parent O Yes O No | Court Order O Yes O 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

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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?
O Yes O No
If yes, provide clerk with your coupons.

Does the patient have Denali Kidcare?
O Yes O No
If yes, please provide clerk the card.

Does the patient have Medicare?
O Yes O No
If yes, please provide clerk the card.

Is the patient a Veteran?
O Yes O No If yes, provide clerk with your fee service card.

Is this a service related injury and/or is it pre-authorized by VA?
O Yes O 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:

Signature: **Date:**

Patient Name:
MR:

PLEASE COMPLETE BOTH PAGES OF THIS FORM