



PATIENT REGISTRATION WORKSHEET

Person Requesting New Chart _____ Organization or Location _____ Phone _____

PLEASE PRINT CLEARLY, ALL INFORMATION IS REQUIRED

NEW CHART MRN _____

Last Name _____ First Name _____ M.I. _____ Suffix _____ Gender _____
 Mailing Address _____ Date of Birth _____ Social Security # _____
 City _____ State _____ Zip _____ Phone Number (907) _____

Preferred Contact Method: Patient Portal Phone Letter No Preference

Race/Heritage: Asian African American White Native Hawaiian/Pacific Islander Other

Is this Patient AK Native or American Indian? Yes No **Hispanic or Latino?** Yes No

Tribe: _____ **Are you Homeless?** Yes No

Do you have Advanced Directives? Yes No **Is there a copy on file with A.N.M.C.?** Yes No

Do you have a designated Power of Attorney or Legal Guardian? Yes No **Do we have a copy on file?** Yes No

Marital Status: Single Married Divorced Separated Widowed Life Partner

Preferred Language: _____ **Do you need an Interpreter?** Yes No

Have You Served in the Armed Forces? Yes No **Branch?** _____ **V.A. Benefits?** Yes No

EMPLOYMENT Full Time Employed Part Time Employed Unemployed Full Time or Part Time Student
 Self Employed _____ Retired Date of Retirement _____

Employer Name _____

GUARANTOR INFORMATION (if patient is a minor, list who is responsible for this patient)

Relationship to Patient _____ Social Security # _____ Gender _____

Last Name: _____ First Name: _____ MI: D.O.B. _____

Mailing Add. _____

City: _____ State: _____ Zip Code: _____

Home Phone _____ Cell Phone _____ Employer _____

OFFICE USE ONLY

Eligibility Pending Ineligible Direct Only PRC and Direct
 VA Contract Department of Defense Commissioned Officer
 Apu Student Dependent of Commissioned Officer
 Employee Employee Health Only Non Ben / Other _____

Ketchikan Indian Community Patient Registration Worksheet

ADDITIONAL INFORMATION

Does this patient have Medicaid? Yes No Denali Kid Care? Yes No Medicare? Yes No

If IHS only, please refer to Health Benefits Specialist

PRIMARY INSURANCE INFORMATION

Scan Both Sides of Insurance Card

Ins. Company: _____ Policy Holder: _____ Policy Holder D.O.B. _____

Policy Number: _____ Group Number: _____ Policy Holder Phone: _____

Policy Holder Employer: _____ Policy Holder Social Security # _____

Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Scan both sides of Insurance Card

Insurance Company: _____ Policy Holder: _____ Policy Holder D.O.B.: _____

Policy Number: _____ Group Number: _____ Policy Holder Phone: _____

Policy Holder Employer: _____ Policy Holder Social Security #: _____

Relationship to Patient: _____

NEXT OF KIN

Relationship to Patient _____ Last Name _____ First Name: _____

Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone: (____) _____

EMERGENCY CONTACT

Relationship to Patient _____ Last Name _____ First Name: _____

Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone: (____) _____

ADDITIONAL CONTACT

Relationship to Patient _____ Last Name _____ First Name: _____

Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone: (____) _____

I understand that by coming to see a provider at KICTHC 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 KICTHC 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, and that federal Privacy law permits KICTHC to release certain health information to those insurers I have identified as being responsible for payment. I hereby assign my rights to such claims to KICTHC along with any benefits that I would otherwise be payable to me. I also agree to assist KICTHC pursue these claims and hereby authorize KICTHC to release medical information and take other steps that may be reasonable necessary to do so. I understand that I may be personally responsible for some financial costs in accordance with KICTHC's policies and procedures.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ MRN: _____