

LAST NAME _____ FIRST _____ MI _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

GENDER: Male Female MARITAL STATUS: Single Divorced Widow VETERAN: Yes No

City, State of Birth _____ Other Names Used _____

Mailing Address _____

Phone/Cell: _____ PO Box/Street _____ City _____ State _____ Zip Code _____

Work Phone: _____ Email: _____ Employer: _____

PLEASE COMPLETE FOR PATIENTS 0-18 YEARS OF AGE

Fathers Name _____ Date of Birth _____

Employer _____ Work Phone _____

Mother's Name _____ Date of Birth _____

Employer _____ Work Phone _____

INSURANCE INFORMATION FOR BILLING, ARE YOU COVERED BY:

Medicare Yes No If Yes, ID# _____

Medicaid Yes No If Yes, ID # _____

Denali Kidcare Yes No If Yes, ID# _____

Veterans Affairs Yes No If Yes, ID# _____

Health Not Federal Yes No If Yes, ID# _____

Secondary Insurance Company _____ Effective Date _____ Policy # _____ Group # _____

Primary Policy Holder's Name _____ Date of Birth _____ Group # _____

Dependent(s) Name _____

Please list additional insurance coverage on back of form

POLICY HOLDER

Name _____ Phone # _____ Relationship _____

Address _____

PO Box/Street _____ City _____ State _____ Zip Code _____

EMERGENCY CONTACT

Name _____ Phone # _____ Relationship _____

Address _____

PO Box/Street _____ City _____ State _____ Zip Code _____

I attest all the information above to be correct. _____

Signature of Patient

Date