SEARHC
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

PATIENT INFORMATION FORM

LAST NAME FIRST MI DATE OF BIRTH SOCIAL SECURITY NUMBER

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

City, State of Birth _____ Other Names Used _____

Mailing Address _____

PO Box/Street City State Zip Code

Phone/Cell: _____ 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 Net 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