PATIENT INFORMATION FORM

Check all that apply:

☐ **Alaska Native (01)**
☐ **Lower 48 American Indian (01)**
☐ **Caucasian**
☐ **Asian** ☐ **Black Or African American**
☐ **Hispanic, Black** ☐ **Hispanic, White**
☐ **US Citizen**
☐ **Civil Services PHS Employee (02)**
☐ **Commissioned Officer (03) or Dependent (04)**
☐ **SEARHC Employee or Dependent (08/33)**
☐ **Native Hawaiian Or Other Pacific Islander**
☐ **Unknown By Patient**
☐ **Alaska Resident**
☐ **Locum/Volunteer (33)**
☐ **Medical Student/Resident (08)**
☐ **Non-Native OB (32)/Family Member(18)**

PATIENT INFORMATION

_____ _____ _____
LAST NAME FIRST M.I. **DATE OF BIRTH** **SOCIAL SECURITY NUMBER**

GENDER: ☐ MALE ☐FEMALE **MARITAL STATUS**: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOW **VETERAN**: ☐YES ☐NO

CITY AND STATE OF BIRTH: _____ **OTHER NAMES USED**:_____

CURRENT COMMUNITY: _____ **(DATE MOVED TO CURRENT COMMUNITY):**_____

MAILING ADDRESS:_____
PO BOX/STREET **CITY** **STATE** **ZIP CODE**

HOME/CELL PHONE:_____ **MESSAGE PHONE:**_____

PATIENT'S EMPLOYER:_____ **WORK PHONE:**_____

SPOUSE'S EMPLOYER:_____ **WORK PHONE:**_____

PLEASE COMPLETE FOR PATIENTS 0-18 YEARS OF AGE:

FATHER'S NAME:_____ **CITY AND STATE OF BIRTH:**_____

EMPLOYER:_____ **WORK PHONE:**_____

MOTHER'S MAIDEN NAME:_____**CITY AND STATE OF BIRTH:**_____

EMPLOYER:_____ **WORK PHONE:**_____

INSURANCE INFORMATION FOR BILLING ARE YOU COVERED BY:

MEDICARE ☐ **YES** ☐ **NO** **If YES, ID#**_____ ☐ **COPY**
MEDICAID ☐ **YES** ☐ **NO** **If YES, ID#**_____ ☐ **COPY**
DENALI KIDCARE ☐ **YES** ☐ **NO** **If YES, ID#**_____ ☐ **COPY**
VETERANS AFFAIRS ☐ **YES** ☐ **NO** **If YES, ID#**_____ ☐ **COPY**

OTHER INSURANCE COMPANY:_____ **Effective Date :**_____ **Policy#**_____

PRIMARY POLICY HOLDER'S NAME_____ **DATE OF BIRTH**_____ **GROUP#**_____

DEPENDENT(S) NAME_____ **DATE(S) OF BIRTH**_____

PLEASE LIST ADDITIONAL INSURANCE COVERAGE ON BACK OF THIS FORM

FIRST PERSON TO CONTACT IN THE EVENT OF A MEDICAL EMERGENCY:

NAME:_____ **PHONE NUMBER**_____ **RELATIONSHIP**_____

ADDRESS:_____
PO BOX/STREET **CITY** **STATE** **ZIP CODE**

NEXT OF KIN TO GIVE CONSENT FOR TREATMENT & SIGN DOCUMENTS WHEN PATIENT NOT ABLE TO:

NAME:_____ **PHONE NUMBER**_____ **RELATIONSHIP**_____

ADDRESS:_____
PO BOX/STREET **CITY** **STATE** **ZIP CODE**

I attest all the information above to be correct: _____

Signature of Patient **Date Signed**