Sitka Medical Center

700 KATLIAN STREET SUITE E, SITKA, AK 99835 (907) 747-5861

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid	Birth date: / /	Se ❑

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Home phone no.: ( )

Street address:	Social Security no.:	Cell phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )
Preferred Language		

ETHNICITY AND RACE

○ Caucasian	○ Asian	○ American Indian or Alaskan Native	○ Pacific Islander
○ African American	○ Hispanic	○ Native Hawaiian	○ Other
Race ○ Other		○ Latino or Hispanic	○ Decline

RESPONSIBLE PARTY

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance? ❑ Yes ❑ No Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative :	Relationship to patient:	Home phone no.: ( )	Work phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am finar responsible for any balance. I also authorize Sitka Medical Center or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Effective 07/01/2014