Alaska Urgent Care

PATIENT REGISTRATION FORM

Welcome to Alaska Urgent Care

Patient Information

Name (Last) ______________________ (First) ______________________ (MI) ______

SSN: ____-____-______ DOB: ____/____/____ Age: ______ Sex: ☐ F ☐ M Martial Status: ☐ S ☐ M ☐ D ☐ W

Mailing Address (Street) ____

City ______________________ State ______________________ Zip __________

Home Phone ______________________ Cell Phone ______________________

Occupation ______________________ Employer ______________________ Work Phone ______________

If patient is a minor or incapacitated adult, please provide:

Parent/Guardian Name ______________________ Parent/Guardian Phone ______________________

Emergency Contact: Name ______________________ Phone ______________ Relationship ______________

Primary Insurance

☐ None

Name/Policy Holder ______________________ SSN: ____-____-______ DOB: ____/____/____

Policy Holder Phone # ______________________ Patient's Relationship to Policy Holder ______________

Insurance Company ______________________ Group # ______________ ID # ______________

Secondary Insurance

☐ None

Name/Policy Holder ______________________ SSN: ____-____-______ DOB: ____/____/____

Policy Holder Phone # ______________________ Patient's Relationship to Policy Holder ______________

Insurance Company ______________________ Group # ______________ ID # ______________

Financial Responsible

☐ Same as Patient

Name (Last) ______________________ (First) ______________________ (MI) ______

SSN: ____-____-______ DOB: ____/____/____ Age: ______ Sex: F M Martial Status: S M D W

Mailing Address ____

Home Phone ______________________ Cell Phone ______________________

If you have been in an accident (auto, work, other), please ask for our Accident Form.

Financial Policy

Thank you for choosing Alaska Urgent Care. We are happy to file your insurance for you. Payment for your estimated portion is due at the time of your service. If you cannot verify your insurance, or you are self-pay, payment in full will be required at the time of service. You will be responsible for any fees not covered by your insurance.

Consent, Authorization, and Release

- Authorization for Treatment: I voluntarily consent to treatment at Alaska Urgent Care for myself, or my dependent named below.
- Assignment of Insurance Benefits: I authorize insurance benefits to be paid to Alaska Urgent Care.
- Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to my insurance or any other third party payer. I also understand that if my insurance is accepted, I must pay all applicable insurance co-pays and deductibles. If my insurance cannot be verified at the time of service, I will pay in full for all services.
- Release of Records: I authorize Alaska Urgent Care to release information to other health-care providers, treatment facilities, and my insurance companies for the purposes of treatment, health-care operations, and payment.

Patient Signature ____ Date ________________________

Parent or Guardian Name ____

Parent or Guardian Signature ____ Date ________________________