ALASKA URGENT CARE

PATIENT REGISTRATION FORM

WELCOME TO ALASKA URGENT CARE

PATIENT INFORMATION

LAST NAME_____ FIRST NAME_____ MI _____

SSN _____ DOB:_____ AGE: _____ SEX F OR M MARTIAL STATUS S M D W

MAILING ADDRESS (STREET) _____

CITY _____ STATE _____ ZIP _____

HOME PHONE_____ CELL PHONE _____

OCCUPATION_____ EMPLOYER_____ WK PHONE _____

EMERGENCY CONTACT: NAME _____ PHONE _____ RELATIONSHIP _____

IF PATIENT IS A MINOR OR INCAPACITATED ADULT, PLEASE PROVIDE:

PARENT/GUARDIAN NAME _____ PHONE _____

ALASKA URGENT CARE BILLS INSURANCE AS A COURTSEY TO OUR PATIENTS, PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE TO AVOID DELAY IN PROCESSING CLAIMS. IF INFORMATION IS NOT SUFFICIENT, WE WILL BILL THE PATIENT/GUARANTOR.

I, THE PATIENT, WOULD LIKE MY VISTS AT ALASKA URGENT CARE BILLED AS (CIRCLE ONE)**: URGENT CARE OR MEDICAL OFFICE VISIT**

PRIMARY INSURANCE

IF YOU HAVE MEDICARE DO YOU HAVE A HMO? YES / NO IF YES WHO IS YOUR HMO CARRIER_____

NAME/POLICY HOLDER_____ SSN:_____-_____-_____ DOB: _____/_____/_____

POLICY HOLDER PHONE: _____ PATIENT'S RELATIONSHIP TO POLICY HOLDER_____

INSURANCE COMPANY_____ GROUP _____ ID# _____

SECONDARY INSURANCE

NAME/POLICY HOLDER _____ SSN: _____-_____-_____ DOB: _____/_____/_____

POLICY HOLDER PHONE: _____ PATIENTS RELATIONSHIP TO POLCY HOLDER _____

INSURANCE COMPANY _____ GROUP _____ ID# _____

FINANCIAL RESPONSIBLE PARTY ☐ PATIENT

NAME (LAST) _____ FIRST _____ MI _____

SSN: _____-_____-_____ DOB: _____/_____/_____ AGE: _____ SEX F OR M MARITAL 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.