MRN #_____

AIHSC PATIENT REGISTRATION

PATIENT INFORMATION

☐MALE ☐FEMALE

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____ MAIDEN NAME _____

DATE OF BIRTH ____/____/____ SOCIAL SECURITY NUMBER _____/____/_____

STREET ADDRESS (MAILING ADDRESS) _____ CITY _____ STATE _____ ZIP CODE _____

PHYSICAL LOCATION OF HOME (if different from mailing address) CITY _____ STATE _____ ZIP CODE _____

HOME PHONE (____)_____ CELL PHONE (____)_____ EMAIL ADDRESS _____

PREFERRED METHOD OF CONTACT: Email ☐ Phone ☐ Letter ☐ Do Not Notify

Do we have permission to send generic health information to the listed email address? ☐ Yes ☐ No

MARITAL STATUS: ☐Divorced ☐Married ☐Never Married ☐Separated ☐Single ☐Widow(er) ☐Other___

ETHNICITY: ☐Hispanic or Latino ☐Non-Hispanic OR Latino ☐Declined to Answer

RACE: ☐American Indian/Alaska Native ☐Asian ☐Black/African-American ☐ Native Hawaiian/Pacific Islander ☐White

PREFERRED LANGUAGE (including sign language) _____ Interpreter Required? ☐ YES ☐ NO

TRIBAL AFFILIATION:_____ TRIBE QUANTUM:_____ OTHER TRIBE:_____

Are you a migrant worker? YES NO Are you currently homeless? YES NO

Did you serve in the military? Yes NO

PARENT/GUARDIAN INFORMATION: COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE

MOTHER'S INFORMATION:

FULL LEGAL NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER (____)_____ EMAIL ADDRESS _____

EMPLOYER NAME _____

EMPLOYER CITY _____ EMPLOYER PHONE (____)_____

FATHER'S INFORMATION:

FULL LEGAL NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER (____)_____ EMAIL ADDRESS _____

EMPLOYER NAME _____

EMPLOYER CITY _____ EMPLOYER PHONE (____)_____

EMERGENCY CONTACT INFORMATION (Please list two different contacts here)

EMERGENCY CONTACT NAME _____ PHONE NO. _____ RELATIONSHIP _____ STREET ADDRESS _____ CITY _____ STATE ____ ZIP ____

NEXT OF KIN NAME _____ PHONE NO. _____ RELATIONSHIP _____ STREET ADDRESS _____ CITY _____ STATE ____ ZIP ____

EMPLOYMENT INFORMATION: COMPLETE IF YOU ARE CURRENTLY EMPLOYED

EMPLOYER NAME_____PHONE NUMBER (____)_____

INSURANCE INFORMATION:

Please provide a copy of your insurance card(s) at the time you submit this form.

Primary Insurance:

INSURANCE COMPANY NAME _____ POLICY HOLDER NAME _____

POLICY NUMBER _____ GROUP NUMBER _____ GROUP NAME _____

Secondary Insurance:

INSURANCE COMPANY NAME _____ POLICY HOLDER NAME _____ (____)_____ PHONE NUMBER

POLICY NUMBER _____ GROUP NUMBER _____ GROUP NAME _____

Other Members on Policy:

Name	Relationship	Chart Number	Date of Birth

I, THE UNDERSIGNED CERTIFY THAT THE INFORMATION CONTAINED ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE. FUTHERMORE, I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM FOR TREATMENT, PAYMENT, OR OPERATIONS.

PATIENT SIGNATURE X _____ DATE_____

RESPONSIBLE PARTY'S SIGNATURE_____ DATE_____