

Patient Registration Worksheet

General Information

Note: Please fill in every blank or check every response. Use N/A if applicable.



Date			
Month	Day	Year	

Sex

\bigcirc
Female
\bigcirc
Male

Full Name *

First Name	Middle Name	Last Name

Other Names (Maiden, Former, Nickname, Etc.)

First Name	Last Name





Date of Birth *



Birth Place *

Social Security Number

Internet Access

○ Yes ○ No

Where do you have access?

O Work O Home O Other



Current Physical Address *

Street Address	
Street Address Line 2	
City	State / Province

Postal / Zip Code

When did you move to current address?

Month	Day	Year	

Current Mailing Address: *

Street Address	
Street Address Line 2	
City	State / Province
Postal / Zip Code	

Home Phone Number *

Please enter a valid phone number.



Cell Phone Number *

Please enter a valid phone number.

Native American Eligibility

Is Patient Alaskan Native or American Indian?

~

Race/Heritage:

○
Asian
○
African American
○
White

O Other

Enrollment Number:

Blood Quantum:

Tribe: *



If Yes, Which Parent?

\bigcirc
Mother
\bigcirc
Father

Your Blood Quantum:

Are you from a Federally Recognized Tribe?

○ Yes ○ No

If Yes, which Tribe? *

Enrollment Number:

Do you have your enrollment information with you?

○ Yes ○ No

Advanced Directives/Power of Attorney



Do you have Advanced Directives?

○ Yes ○ No

Is there a copy on file with CAIHC?

○ Yes ○ No

Do you have a designated Power of Attorney?

○ Yes ○ No

Do you have a copy on file with CAIHC?

⊖ Yes ⊖

No

Married Status

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Marital Status:

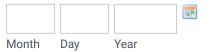
Married
Married
Divorced
Seperated
Widowed
Life Partner
Single

Employment Information

Employment Status:

Full Time
Part Time
Unemployed
Full/Part Time Student
Self Employed
Retired

If Retired, Date of retirement:





Employers Name:

Title/Position:

Employers Address:

Street Address	
Street Address Line 2	
City	State / Province
Postal / Zip Code	

Work Phone:

Please enter a valid phone number.

Have you served in the Armed Forces?

○ Yes ○ No

INO

If Yes, which Branch?





Do you have V.A. Benefits?

○ Yes ○ No

Guarantor Information

If patient is a minor, list who is responsible for this patient.

Relationship to Patient: (Use "self" if you are the patient) *

Social Security Number:

Gender: *		
\bigcirc		
Mal	e	
\bigcirc		
Ferr	nale	
\bigcirc	Other	

Full Name: *

First Name	Middle Name	Last Name

Date of Birth: *





Employer

Current Mailing Address: *

Street Address	d
Street Address Line 2	
City	State / Province
Postal / Zip Code	4

Home Phone: *

Please	enter	а	valid	phone	number.

Cell Phone: *

******Important Note:** If I.H.S Beneficiary Patient ONLY, please refer to CAIHC's Health Benefits Specialist*****

Insurance Information

Primary Insurance:

Company Name: *

Insurance Company Phone number: *

Please enter a valid phone number.

Insurance Type:



Coverage Type:

\bigcirc
Single
\bigcirc

Family

Insurance Source:

0
Employer
\bigcirc
Group
\bigcirc
Non-Group
Other



Group Number: *

Policy Number: *

BIN Number: *

PCN Number: *

Person Code:

Insurance Coverage Start Date *

Month	Day	Year	

Insurance Coverage End Date *

Month	Day	Year	

Services Covered:

- □ Medical
- Dental
- Vision
- Prescription



Policy Holders Name: *

First Name	Last Name

Primary Care Physician: *

First Name	Last Name

PCP Number: *

Policy Holder Address:

Street Address	
Street Address Line 2	
City	State / Province
Postal / Zip Code	

Policy Holder's Gender: *

⊖ Female

⊖ Male

Policy Holders Date of Birth: *





Policy Holders Social Security Number:

Do you have secondary insurance?

⊖ Yes			
O No			

Do you have Medicare?

○ Yes ○ No

Do you have Medicaid?

○ Yes ○ No

Do you have Denali Kid?

○ Yes ○ No

Secondary Insurance:



Insurance Company Phone Number:

Please enter a valid phone number.

Insurance Type:

O PPC)	
0	-	
HM	0	
\bigcirc	Other	

Coverage:

\bigcirc
Single
\bigcirc
Family

Source:

\bigcirc
Employer
\bigcirc
Group
\bigcirc
Non-Group

O Other

Group Number:

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Policy Number:

BIN Number:

PCN Number:

Person Code:

Insurance Coverage Start Date:

Month	Day	Year	

Insurance Coverage End Date:

Month	Day	Year	

Services Covered:

- \Box Medical
- Dental
- Vision
- Prescription

Policy Holders Name:

First Name Last Name

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Primary Care Physician:

First Name	Last Name

PCP Number:

Policy Holders Address:

Street Address	
Street Address Line 2	
City	State / Province
Postal / Zip Code	

Policy Holders Gender:

O Female O Male

Policy Holders Date of Birth:

Month	Day	Year	

Policy Holders Social Security Number:

Medicare Insurance:





Medicare:

\bigcirc
Yes
\bigcirc
\bigcirc
No

Medicare Number:

Medicare Plan Number:

Prescription Plan Name:

Effective Date for Plan A:

Effective Date for Plan B:

Effective Date for Plan D:

Medicaid Insurance:



Medicaid:

\bigcirc
Yes
\bigcirc
No

Eligibility Dates:

Medicaid Number:

Designated Provider:

First Name Last Name

Coverae Type:

⊖ Full ⊖ Basic

Denali Kid Care Insurance:

Denali Kid Care:

\bigcirc
Yes
\bigcirc
No



Eligibility Dates:

Denali Kid Care Number:

Designated Provider:

First Name Last Name

Coverage Type:

⊖ Full ⊖ Basic

Veteran Insurance:

Service Branch (Last):

Service Entry Date (Last):

Service Seperation Date (Last):

Vietnam Services Indicated?



Service Connected:

Claim Number:

Description of VA Disability:

Valid VA Card:

DD214 Available:

Emergency Contact Information:

Full Name: *

First Name	Last Name



Phone Number *

Please enter a valid phone number.

Relationship: *

Address *

Street Address		
Street Address Line 2		
City	State / Province	
Postal / Zip Code		

Additional Contact Information:

×

Do you have additional contact information?

Name *

First Name

Last Name



Phone Number *

Please enter a valid phone number.

Relationship: *

Address *

Street Address	
Street Address Line 2	
City	State / Province
Postal / Zip Code	

Certification Statement:

I certify and attest that the information in this Patient Registration Worksheet is correct, to the best of my knowledge and belief. I understand that falsification of information may subject me to denial of CAIHC's Purchase Referred Care (PRC) Student Education Program. This Worksheet must be completed yearly or until the Student Education Program has been completed, and delivered to CAHIC's PRC Program.

Name

First Name	Last Name



Today's Date



