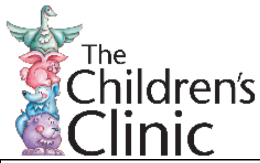

New Family Registration Form

Patient Information			
First Name: «PFirst»	Middle: «PInit»	Last: «PLast»	Suffix: «PSuffix»
DOB: «PDOB»	Sex: «PSex»		
Mailing Address:		City:	State: Zip:
Preferred phone number for appointment confirmations:			
Patient lives with:	Who should receive mail regarding balances and appointments?		
Preferred Physician:			

Primary Guarantor Information			
First Name:	Middle:	Last:	Suffix:
DOB:	Sex:	SSN:	Relationship to Patient:
Cell Phone:	Home Phone:	Work Phone:	
Mailing Address:		City:	State: Zip:
Employer:	Occupation:		

Additional Parent or Guardian Information			
First Name:	Middle:	Last:	Suffix:
DOB:	Sex:	SSN:	Relationship to Patient:
Cell Phone:	Home Phone:	Work Phone:	
Mailing Address:		City:	State: Zip:
Employer:	Occupation:		

Primary Insurance			
Insurance Name:	Subscriber ID:	Group ID:	
Subscribers Name:	Date of Birth:	Relationship to Patient:	
If the subscriber is not listed above, please complete the information below.			
Mailing Address:	City:	State:	Zip:
Cell Phone:	Home Phone:	Work Phone:	

Secondary Insurance			
Insurance Name:	Subscriber ID:	Group ID:	
Subscribers Name:	Date of Birth:	Relationship to Patient:	
If the subscriber is not listed above, please complete the information below.			
Mailing Address:	City:	State:	Zip:
Cell Phone:	Home Phone:	Work Phone:	

Emergency Contact Name:	Phone:	Relationship to Patient:
Patient's Siblings(s) Name	Date of Birth:	Lives With:
Patient's Siblings(s) Name	Date of Birth:	Lives With:
Patient's Siblings(s) Name	Date of Birth:	Lives With:

How did you hear about The Children's Clinic? ☐ Internet ☐ Facebook ☐ AK Parent Magazine ☐ Dispatch News ☐ Yellow Pages
☐ Insurance Company ☐ Friend (name) ☐ Doctor (name) ☐ Other

The Children's Clinic bills your insurance as a courtesy. Payment is expected at the time of the service for co-payments, deductibles, and any services and supplies not covered by insurance / Medicaid. I acknowledge that The Children's Clinic will bill my insurance as a courtesy and that I am responsible for the balance. I authorize The Children's Clinic to release all information necessary to secure the payment of medical benefits and for said benefits be paid directly to The Children's Clinic.

Signature of Parent / Legal Guardian:____ Date: ____________