



# FRONTIER HEALTH AND WELLNESS, LLC

## Patient Registration Form – Pediatric/Under Guardianship



Date					
Patient Full Legal Name (First, Middle Initial, Last)			Prefix	Suffix	Previous Name(s)/Alias:
Date of Birth	Age	Sex	Gender Identity		Preferred Pronoun
School			Grade	Contact Number	

### Guardianship (If guardianship is anything other than shared or 50/50 FHW Must had legal documentation on file prior to any appointment)

Parent/Guardian Name (G1):		Parent/Guardian Name (G2):	
Guardian listed above guardianship status: <input type="checkbox"/> Shared <input type="checkbox"/> Primary <input type="checkbox"/> Sole		Guardian listed above guardianship status: <input type="checkbox"/> Shared <input type="checkbox"/> Primary <input type="checkbox"/> Sole	
G1 Preferred Phone Number		G2 Preferred Phone Number	
Can we leave a Voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No		Can we leave a Voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	
G1 Secondary Contact Number:		G2 Secondary Contact Number:	
<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other	
G1 Address		G2 Address	
City, State	Zip Code	City, State	Zip Code

Reason for choosing Frontier Health and Wellness		
<input type="checkbox"/> Recommendation from Family/Friend <input type="checkbox"/> Location/Convenience <input type="checkbox"/> Referral from Provider <input type="checkbox"/> Search Engine <input type="checkbox"/> Insurance <input type="checkbox"/> Other		
If referred by hospital or provider, please list who:		
Preferred Pharmacy	Address	Contact Number
Emergency Contact	Relationship	Contact Number

### Please Do Not Include Information on Denali KidCare, Medicaid, or Medicare - We Do Not Accept These Plans

Financially Responsible Party	Address	Contact Number
Primary Insurance Carrier (Do Not Include Medicaid/DKC/Medicare)	Subscribers Name	
Policy Number/Member ID (Do Not Include Medicaid/DKC/Medicare)	Group Number	
Patients Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4
Secondary Insurance Carrier (Do Not Include Medicaid/DKC/Medicare)	Subscribers Name	
Policy Number/Member ID (Do Not Include Medicaid/DKC/Medicare)	Group Number	
Patients Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4

I certify that my answers are true and complete to the best of my knowledge. I authorize my insurance benefits to be paid directly to my provider. I understand that I am financially responsible for any balance accrued. I also authorize Frontier Health and Wellness and/or its Contracted Providers to release any information required to process my claims.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_