

FRONTIER HEALTH AND WELLNESS, LLC

Patient Registration Form – Adult



Date				
Patient Full Legal Name (First, Middle Initial, Last)		Prefix	Suffix	Previous Name(s)/Alias:
Previous Name(s):		Date of Birth	Age	Sex
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other		Preferred Pronoun		Gender Identity
Patient Preferred Phone Number Can we leave a Voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No		Secondary Number: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other		Last 4 of SS#
Physical Address		City, State		Zip Code
Mailing Address		City, State		Zip Code
Occupation		Employer		Contact Number

Reason for choosing Frontier Health and Wellness <input type="checkbox"/> Recommendation from Family/Friend <input type="checkbox"/> Location/Convenience <input type="checkbox"/> Referral from Another Provider <input type="checkbox"/> Search Engine <input type="checkbox"/> Insurance <input type="checkbox"/> Other		
If referred by hospital or clinician, 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 (if other than patient)	Address	Contact Number
Primary Insurance Carrier (Do Not Include Medicaid/DKC/Medicare)	Subscribers Name If same, please do not complete the next 2 rows	
Policy Number/Member ID (Do Not Include Medicaid/DKC/Medicare)	Group Number	
Patient's Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4
Secondary Insurance Carrier (Do Not Include Medicaid/DKC/Medicare)	Subscribers Name If same, please do not complete the next 2 rows	
Policy Number/Member ID (Do Not Include Medicaid/DKC/Medicare)	Group Number	
Patient's 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: _____