FRONTIER HEALTH AND WELLNESS: PATIENT REGISTRATION FORM

Frontier Health and Wellness will utilize the information provided to complete your patient profile, provide your provider with necessary demographic information and allow our contracted billing service to contact and bill your insurance provider(s).

Today's Date:	Client: ○ Adult ○ Child	If client is a child, then include guardian's name above				
Primary Care Provider (Clinic Name):						
Client's last name: First: Middle:	○ Mr. ○ Miss ○ Mrs. ○ Ms	Marital status Single / Mar / Div / Sep / Wid ☐ ☐ ☐ ☐ ☐				
Is this your legal name? ○ Yes ○ No	If not, what is your full legal name?	Any other Former name(s):	Birth date:	Preferred Pronoun: ○ He/Him ○ She/Her ○ They/Them	Gender ○ M ○ F ○ Prefer not to disclose	
Physical address:		Social Security no.:	Best phone # to reach you: ( )			
Mailing Address:	City:	State:	ZIP Code:			
Occupation/Grade:	Employer/School:	Employer/School phone number: ( )				
Preferred Pharmacy Name	Pharmacy Address	Pharmacy Phone Number				
I choose this clinic because (please indicate your referral source): ☐ Family/Friend ☐ Location ☐ Search Engine ☐ Another Provider ☐ Hospital ☐ Insurance Plan ☐ Other						
Other family members seen here:						

INSURANCE INFORMATION

(Please give your ID and insurance card to the receptionist. so we can make a copy for our records)

Person responsible for bill:	Birth date: / /	Address (if different):	Best phone # to reach you: ( )
Is this person a patient here? ☐ Yes ☐ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Please note that this clinic is NOT set up to receive payments from Medicaid/Medicare/Denali Kid Care.

Is this client covered by insurance (other than Medicaid/Medicare/Denali Kid Care)? ☐ Yes ☐ No			
Please indicate primary insurance company:	Group no.:	Policy no.:	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Co-payment: $
Client's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Client's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Frontier Health and Wellness or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*