Alyeska Family Medicine
State of the Art Care, Traditional Values

REGISTRATION FORM

PATIENT INFORMATION
(Please Print)

Patient's last name:	First:	Middle:	Prefix	Suffix	Marital status	Sex: ❑ M ❑ F

Preferred Name (Nickname):	(Maiden Name):	Birth date:	Social Security no.:	Drivers License no./ State

Mailing Address:	City:	State:	ZIP Code:
Street Address:	City:	State:	ZIP Code:

Home phone no.:	Cell Phone no.:	Employer phone no.:	Preferred Contact Method: ❑ Phone ❑ Mail ❑ Portal

How did you hear about us? (please check one box): ❑ Dr. ______________ ❑ Insurance Plan ❑ YP.COM
❑ Family/Friend (Name)______________________ ❑ Phone Book ❑ Our Website ❑ Other ____________________

Living Will: ❑ Yes ❑ No	Advance Directives *(If yes, please provide copy)*: ❑ Yes ❑ No

INSURANCE INFORMATION
(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Social Security no.:	Sex: ❑ M ❑ F

Mailing Address:	City:	State:	ZIP Code:

Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Is this patient covered by insurance? ❑ Yes ❑ No

Name of Primary insurance	Subscriber's Name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance *(if applicable):*	Subscriber's Name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:

Patient'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.:

_______________________________________ _______________________
Patient/Guardian signature *Date*