PATIENT REGISTRATION DATA

Patient's Legal Name:	Patient's Date of Birth: / /	Sex: Male Female	Social Security Number ___ - ___ - ___
Addresses (including City, State and Zip Code): Mailing: Physical:			Home phone: Cell phone: Work phone:
Email Address:			
Preferred Language:	Hearing impaired: Y / N	Visually impaired: Y / N	Needs interpreter: Y / N

Marriage Status: S M W D Sep Religion:	Race: (please check one) ☐ American Indian or Native Alaskan ☐ Asian ☐ Black or African American ☐ Caucasian ☐ Native Hawaiian or Other Pacific Islander	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

(For Patient or Parent) Employer's Name: ______________________________ Occupation: ______________________________

Employment Status: (Check One) Full Time Part Time Not Employed Student Disabled Retired

Who is the patient's primary Care physician?	If retired, please list your retirement dates ________ and your spouses's retirement dates ________ .	
Emergency Contact Person (s)	Relationship to Patient	Phone Numbers: ___ - ___ - ___ ___ - ___ - ___
Emergency Contact Person (s)	Relationship to Patient	Phone Numbers: ___ - ___ - ___ ___ - ___ - ___
If patient is a minor, who may authorize treatment?	Relationship to Patient	Phone Numbers: ___ - ___ - ___ ___ - ___ - ___

Guarantor's Name (If other than self):	Guarantor Date of Birth / /	Sex:	Social Security Number ___ - ___ - ___
Relationship to patient:	Mailing Address including City, State and Zip Code:		Home phone: Cell phone: Work phone:

Insurance Company	Primary:	Secondary:
I.D. Number		
Subscriber Name		
Subscriber DOB		
Subscriber SSN		
Subscriber Address		
Employer/Group #		
Co Payment Amt		

I authorize Central Peninsula Hospital to release to the named insurance company(s) any information that is necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.

Responsible Party Signature ______ Relationship to Patient ______ Date ______ Time ______

Address of Responsible Party ______ Phone ______ Witness Signature ______

SS# ______ DL# ______ DOB# ______ Date ______ Time ______

250 Hospital Place, Soldotna, AK 99669

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