

REGISTRATION

(Please Print)

SITKA MEDICAL CENTER

700 Katlian St., Suite E

Sitka, AK 99835

Telephone: (907) 747-5861

SSN _____

Date _____

Patient _____

DOB _____

Sex: Female Male Marital Status: S M SEP D W

Mailing Address _____ Home Phone# _____

Street Address _____ Cell Phone # _____

City/State/Zip Code _____ Work Phone # _____

Employer Name _____ Occupation _____

Employer Address _____ City/State/Zip Code _____

Email address _____

Ethnicity: (Required)		Race: (Optional)	
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Native American	<input type="checkbox"/> Black Non-Hispanic	<input type="checkbox"/> Latino/Hispanic
<input type="checkbox"/> African American	<input type="checkbox"/> Asian Pacific American	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Decline	
<input type="checkbox"/> Asian	<input type="checkbox"/> Subcontinent Asian American	Language: _____	
<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> American Indian/Alaskan Native		

PERSON RESPONSIBLE FOR PATIENT'S FINANCIAL OBLIGATIONS, IF SELF, INDICATE SELF

Name _____ DOB _____ SSN _____

Relationship _____ Home Phone # _____ Work Phone# _____ Cell Phone# _____

Mailing Address (If different from Patient's address) _____

Street Address (If different from Patient's address) _____

City/State/Zip Code _____

Employer _____ Occupation _____

IN CASE OF EMERGENCY

Name _____ Relationship _____

Home Phone# _____ Work Phone# _____ Cell Phone# _____

Street Address _____ City/State/Zip Code _____

PATIENT INSURANCE INFORMATION

Do you have health insurance? Yes No If yes, see scanned _____

Do you have Medicaid? Yes No

Do you have Medicare? Yes No

ASSIGNMENT OF BENEFITS

I hereby do authorize and direct my insurance company to make payment to SITKA MEDICAL CENTER, benefits allowable and otherwise payable to me and/or my dependents. I understand that I am responsible for charges not paid under this assignment. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature in all my insurance submissions.

PATIENT'S SIGNATURE _____ DATE _____

MEDICARE AUTHORIZATION (only)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to SITKA MEDICAL CENTER for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S SIGNATURE _____ DATE _____

PRIVACY DISCLOSURE

I have received the Notice of Privacy Practices sheet and I have been provided an opportunity to review it.

PATIENT'S SIGNATURE _____ DATE _____