Dahl Memorial Clinic

PATIENT REGISTRATION FORM

Patient Information

Last Name	First Name	Middle Name

Social Security #	Date of Birth	Gender: ☐ Male ☐ Female

Billing Address (PO or Street)	(City)	(State)	(Zip)	(Country)

Secondary Address (i.e. winter/permanent)	Use ____/____/_____ To ____/_____/_____				

Please indicate which one of the contact options below is preferred.

Home Phone #	May we leave a message? ☐ Yes ☐ No	☐ Preferred
Cell Phone #	May we leave a message? ☐ Yes ☐ No	☐ Preferred
Email Address	May we leave a message? ☐ Yes ☐ No	☐ Preferred
Employer Name	Employer Phone #	☐ Preferred

Are You A: ☐ Year Round Resident of Skagway ☐ Seasonal Resident of Skagway ☐ Visitor to Skagway

Patient Demographic Information

In order to qualify for our federal grant, we are required to collect and report certain information for our patient population as a whole. Please help us by checking all applicable in each category. All information is confidential.

VETERAN? ■ Yes ☐ No

PRIMARY LANGUAGE
☐ English
☐ Other: _____

RACE
☐ Caucasian/White ☐ Asian ☐ Native Hawaiian
☐ Black/African American ☐ Other Pacific Islander
☐ Alaska Native/American Indian ☐ More than one Race
☐ Other _____

ETHNICITY
☐ Hispanic
☐ Latino
☐ Not applicable

APPROXIMATE ANNUAL HOUSEHOLD INCOME
☐ $0 to $14,350
☐ $14,351 to $21,525
☐ $21,526 to $28,700
☐ Over $28,700

Individual Responsible for Payment (if other than patient)

Last Name	First Name	Middle

Date of Birth	Relationship to Patient: ☐ Parent/Guardian ☐ Spouse ☐ Other _____

Mailing Address (PO or Street)	(City)	(State)	(Zip)	(Country)

Home Phone #	Cell Phone #	Work #

Emergency Contacts

The Dahl Memorial Clinic may discuss my medical information with the following individuals. I understand that my information will not be discussed with anyone not listed below unless I have given prior written authorization.

Name	Relationship	Phone # 1	Phone # 2
Name	Relationship	Phone # 1	Phone # 2
Name	Relationship	Phone # 1	Phone # 2
Name	Relationship	Phone # 1	Phone # 2

Primary Insurer

Plan Carrier	Policy #	Group #	Effective Date

Policy Holder (if other than patient)	Date of Birth	Phone # 1	Phone # 2	Relationship

Second Insurer

Plan Carrier	Policy #	Group #	Effective Date

Policy Holder (if other than patient)	Date of Birth	Phone # 1	Phone # 2	Relationship

Third Insurer

Plan Carrier	Policy #	Group #	Effective Date

Policy Holder (if other than patient)	Date of Birth	Phone # 1	Phone # 2	Relationship

Sliding Scale Discount

You may be eligible for a discount on the patient responsibility portion of your medical care. Eligibility is based on family size and gross annual income. Please request a copy of the Sliding Discount Application if you have not already received one.

Would you like to apply for the Sliding Scale Today? ☐ Yes (you must complete an application) ☐ No

Release, Assignment and Statement of Responsibility

I authorize the release of medical information necessary to file claims with my insurance company and assign benefits directly to the Dahl Memorial Clinic. I understand that I am financially responsible for amounts not covered by the sliding fee scale or my insurance for myself and any patient for which I am the guarantor of payment. I consent for the Dahl Memorial Clinic to administer treatment and to perform medical procedures as necessary. I acknowledge and agree that I have reviewed a copy of Dahl Memorial Clinic's Notice of Privacy Practices. I acknowledge that I may request a copy of the notice at any time.

Signed: _____ Dated: _____

Printed: _____