Dahl Memorial Clinic

PATIENT REGISTRATION FORM

Patient Information

Last Name	First Name	Preferred name	Middle Initial

Date of Birth	Gender at birth: ☐Male ☐Female	Social Security #	Preferred Provider

Billing Address (PO or Street, City, State, Zip)	(Country)
Secondary Address (i.e. winter/permanent)	

Home Phone #	May we send automated appointment reminders, test result notifications, etc? By Phone Call ☐ Yes ☐ No By Text Message ☐ Yes ☐ No
Cell Phone #	
Email Address	Contact Preference: ☐ Home Phone | ☐ Work Phone | ☐ Cell | ☐ Email(Portal)

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.

PRIMARY LANGUAGE	RACE	ETHNICITY	MARITAL STATUS
☐ English ☐ Other: ________________	☐ Alaska Native/American Indian | ☐ Asian ☐ Black or African American | ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Married | ☐ Single | ☐ Divorced ☐ Separated | ☐ Widowed | ☐ Partner

Choose One:	VETERAN	NUMBER OF PEOPLE IN HOUSEHOLD:	APPROXIMATE ANNUAL HOUSEHOLD INCOME
☐ Year Round Resident of Skagway ☐ Seasonal | ☐ Visitor	☐ Yes ☐ No		☐ < $20,000 | ☐ $20,000 to $40,000 | ☐ $40,000 to $60,000 ☐ 60,000 to $80,000 | ☐ 80,000 to $100,000 | ☐ >$100,000

SEXUAL ORIENTATION:	GENDER IDENTITY:
☐ Lesbian, Gay, Homosexual | ☐ Straight, Heterosexual | ☐ Bisexual | ☐ Other	☐ Male | ☐ Female | ☐ Transgender ☐ Gender Queer | ☐ Other

Employment

Occupation	Employer Name	Employer Phone #

Guarantor

This individual will receive statements and be responsible for payment for this patient: ☐ Self ☐ Other- List Below

Last Name	First Name	Middle

Date of Birth	Patient's relationship to Guarantor: ☐ Spouse ☐ Child ☐ Health Care POA ☐ Other ______________________

Mailing Address

Home Phone #	Cell Phone #	Work #

Emergency Contact(s)

We will attempt to contact the individual(s) listed below during a health crisis in order to inform them of your location and status and obtain medical information if necessary. These should be individuals who know your health history and your preferences about contacting other family and friends.

Name	Relationship	Home/Cell Phone(s)
Name	Relationship	Home/Cell Phone(s)

Primary Insurer

Plan Carrier	Policy #	Group #	Effective Date
Policy Holder: ☐ Self ☐ Named Below	Address	Date of Birth	Relationship to Patient

Second Insurer

Plan Carrier	Policy #	Group #	Effective Date
Policy Holder: ☐ Self ☐ Named Below	Address	Date of Birth	Relationship to Patient

Third Insurer

Plan Carrier	Policy #	Group #	Effective Date
Policy Holder: ☐ Self ☐ Named Below	Address	Date of Birth	Relationship to Patient

Sliding Scale Discount

You may be eligible for a discount on the cost 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, my insurance, or my employer 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 understand that I may request a copy of the notice at any time.

Signed: ____ Dated: ____________________

Printed: ____

Dahl Memorial Clinic

Municipality of Skagway

Consent to Disclose Personal Health Information

We respect your right to privacy regarding medical information. We will NOT share your Personal Health Information (PHI) with any family member, friend, significant other, or spouse without your written consent. If you would like to authorize us to share your PHI with someone, please list them below. This consent form is NOT applicable to Behavioral Health records on file.

I **consent** to allowing the providers and staff of Dahl Memorial Clinic to discuss my PHI, excluding any Behavioral Health records, with my family members, significant other, or my personal representative listed below:

NAME:________________________________**Relationship:**________________**Phone:**_______________

NAME:________________________________**Relationship:**________________**Phone:**_______________

OR

__________ I **restrict** the providers and staff of Dahl Memorial Clinic from discussing my PHI with anyone other than myself.

I understand that I may revoke this consent in writing, but that revocation will not be effected to the extent that Dahl Memorial Clinic has already taken action in reliance on my earlier effective consent.

____
Signature of Patient or Legal Representative

____
Printed Name

____
Witness

____
Date

P.O. BOX 537 SKAGWAY, AK 99840 PHONE 907-983-2255 – Fax 907-983-2793