



New Family Registration Form

Patient Information				
First Name:	Middle:	Last:	Suffix:	
DOB:	Sex:			
Mailing Address:	City:		State:	Zip:
Preferred phone number for appointment confirmations:				
Patient lives with:	Who should receive mail regarding balances and appointments?			
Preferred Physician:				

Parent or Legal Guarantor Information				
First Name:	Middle:	Last:	Suffix:	
DOB:	Sex:	SSN:	Relationship to Patient:	
Cell Phone:	Home Phone:	Work Phone:		
Mailing Address:	City:		State:	Zip:
Employer:	Occupation:			

Additional Parent or Legal Guardian Information				
First Name:	Middle:	Last:	Suffix:	
DOB:	Sex:	SSN:	Relationship to Patient:	
Cell Phone:	Home Phone:	Work Phone:		
Mailing Address:	City:		State:	Zip:
Employer:	Occupation:			

Primary Insurance				
Insurance Name:	Subscriber ID:	Group ID:		
Subscribers Name:	Date of Birth:	Relationship to Patient:		
<i>If the subscriber is not listed above, please complete the information below.</i>				
Mailing Address:	City:		State:	Zip:
Cell Phone:	Home Phone:	Work Phone:		

Secondary Insurance				
Insurance Name:	Subscriber ID:	Group ID:		
Subscribers Name:	Date of Birth:	Relationship to Patient:		
<i>If the subscriber is not listed above, please complete the information below.</i>				
Mailing Address:	City:		State:	Zip:
Cell Phone:	Home Phone:	Work Phone:		

Emergency Contact Name:	Phone:	Relationship to Patient:
Patient's Siblings(s) Name	Date of Birth:	Lives With:
Patient's Siblings(s) Name	Date of Birth:	Lives With:
Patient's Siblings(s) Name	Date of Birth:	Lives With:

How did you hear about The Children's Clinic?	☐ Internet	☐ Facebook	☐ AK Parent Magazine	☐ Anchorage Daily News
	☐ Insurance Company	☐ Friend (name)	☐ Doctor (name)	☐ Other

The Children's Clinic bills your insurance as a courtesy. Payment is expected at the time of the service for co-payments, deductibles, and any services and supplies not covered by insurance / Medicaid. I acknowledge that The Children's Clinic will bill my insurance as a courtesy and that I am responsible for the balance. I authorize The Children's Clinic to release all information necessary to secure the payment of medical benefits and for said benefits be paid directly to The Children's Clinic.

Signature of Parent / Legal Guardian: _____ Date: _____