STATE OF ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

**CLIENT REGISTRATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Office Use Only**: Registration Date: |  | HIPAA Signed? YesNo | CHART #: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PARENT/GUARDIAN INFORMATION FOR MINORS** | | | | | | |
| (Guardian**)** Father’s Last, First Name |  | | | | | |
| City and State of Birth |  | | | | | |
| Employer |  | | | (Self-Employed Unemployed) | | |
| Mother’s Maiden Last, First Name |  | | | | | |
| City and State of Birth |  | | | | | |
| Employer |  | | | (Self-Employed Unemployed) | | |
| **CLIENT INFORMATION** | | | | | | |
| Legal Last, First, and Middle Name/Initial |  | | | | | |
| Previous Names (Not Applicable) |  | | | | | |
| Date of Birth |  | | | | | |
| Social Security Number |  | | | | | |
| Sex | MaleFemale | | | |  | |
| Gender Identity (optional) | MaleFemale  Other (specify): | | | | | |
| Marital Status | Single Married Separated Divorced Widow/Widower | | | | | |
| Mailing Address: Street/PO Box |  | | |  | | |
| City |  | | | State Zip | | |
| City/Village Client currently lives in |  | | | Since Date (or Birth) | | |
| Place of Birth (City/State or Foreign Country) |  | | |  | | |
| Cell Phone |  | | | Work Phone | | |
| Home Phone |  | | | | | |
| May we call or leave messages for you? | Cell  Home  Work  Other: | | | | | |
| May we send mail to your home? | YesNo | | | | | |
| Employer |  | | | (Self-Employed Unemployed) | | |
| Race (check all that apply) | American Indian/Alaska Native Asian White  Black/African American Hawaiian/Pacific Islander | | | | | |
| Primary Language | English Other(specify): | | | | | |
| Interpreter Needed? | YesNo | | |  | | |
| Ethnicity | Hispanic  Not Hispanic | | |  | | |
| Is Client a Veteran? | YesNo | | |  | | |
| **INSURANCE INFORMATION** | | | | | | |
| Private Insurance? | YesNo Uninsured | | |  | | |
| Medicare? | YesNoID# | | | Coverage Starts Date | | |
| Denali Kid Care/Medicaid? | YesNoID# | | | Effective Date | | |
| Primary Health Care Provider (None) |  | | |  | | |
| **EMERGENCY CONTACT INFORMATION** | | | | | | |
| Emergency Contact Name: Last, First |  | | | | |  |
| Emergency Contact Phone # |  | | | | |  |
| Relationship to Client |  | | | | |  |
| ( Same as Client) Mailing Address |  | | | | |  |
| **HOUSEHOLD INCOME ASSESSMENT** | | | | | | |
| Number in Household (including yourself) |  | | | | | |
| Total Household Income (before taxes) per Month $ |  | | | | | |
| **This information is true to the best of my** | **knowledge. Please complete additional household information on second page.** | | | | | |
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|  |  |  | | | | |
| **Client/Guardian Signature Date** | | **Office Use Only: Reviewed by PHN Staff Date** | | | | |
| Form 06-1490 (rev 05/19) |  | | | | | |
| **Other Household Member Names** | **Date of Birth (if known)** | | **Male/Female** | **Relationship to Client** | | |
|  |  | | MaleFemale |  | | |
|  |  | | MaleFemale |  | | |
|  |  | | MaleFemale |  | | |
|  |  | | MaleFemale |  | | |
|  |  | | MaleFemale |  | | |
|  |  | | MaleFemale |  | | |
|  |  | | MaleFemale |  | | |
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|  |  | | MaleFemale |  | | |
|  |  | | MaleFemale |  | | |
|  |  | | MaleFemale |  | | |
|  |  | | MaleFemale |  | | |

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