STATE OF ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

**CLIENT REGISTRATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Office Use Only**: Registration Date: |  | HIPAA Signed? **[ ]** Yes **[ ]** No | 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 | **[ ]** Male **[ ]** Female  |  |
| Gender Identity (optional) | **[ ]** Male **[ ]** Female  **[ ]** 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? | **[ ]** Yes **[ ]** No |
|  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? | **[ ]** Yes **[ ]** No |  |
|  Ethnicity | [ ]  Hispanic [ ]  Not Hispanic |  |
| Is Client a Veteran? | **[ ]** Yes **[ ]** No |  |
| **INSURANCE INFORMATION** |
| Private Insurance? | **[ ]** Yes **[ ]** No **[ ]** Uninsured |  |
| Medicare?  | **[ ]** Yes **[ ]** NoID#  | Coverage Starts Date  |
| Denali Kid Care/Medicaid?  | **[ ]** Yes **[ ]** NoID#  | 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** |
|  |  | **[ ]** Male **[ ]** Female |  |
|  |  | **[ ]** Male **[ ]** Female |  |
|  |  | **[ ]** Male **[ ]** Female |  |
|  |  | **[ ]** Male **[ ]** Female |  |
|  |  | **[ ]** Male **[ ]** Female |  |
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