MUNICIPALITY OF ANCHORAGE DEPARTMENT OF HEALTH AND HUMAN SERVICES

PLEASE PRINT THIS REGISTRATION FORM AND BRING WITH YOU

Client Information

Client's Legal Name: Last, First, Middle Initial _____

Client's Gender ☐ Male ☐ Female Date of Birth: _____

Client's Social Security Number # _____

Client's Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower

Client's Mailing Address: Street/Po Box _____

Client's Mailing Address: City _____ State: _____ Zip: _____

If you are under the age of 18, are you registering yourself independent of your parent or legal guardian: ☐ Yes ☐ No

You will need to provide proof of mailing address to complete registration

Email address _____

	Appointment Information?	Billing Information?
May we use your email to notify you of:	☐ Yes ☐ No	☐ Yes ☐ No

(Home Phone is Cell Phone ☐) Cell Phone _____ Home Phone _____

Work Phone _____ Message Phone _____

May we call or leave messages for you at: ☐ Cell ☐ Home ☐ Work ☐ Message

May we send mail to your home? ☐ Yes ☐ No

Client's Previous Names: _____ ☐ Not Applicable

Client's Race (check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ White ☐ Black/African American ☐ Hawaiian/Pacific Islander

Client's Primary Language ☐ English ☐ Other (specify) _____

Client's Proficiency in English ☐ Well ☐ Not Well Interpreter Needed? ☐ Yes ☐ No

Client's Ethnicity ☐ Hispanic ☐ Not Hispanic

Client Emergency Contact Information

Emergency Contact Name: Last, First, Middle _____

Emergency Contact Phone # _____ **May we text contact:** ☐ Yes ☐ No

Relationship to Client _____

Children (First and Last Name)	Birth Date	Male/Female	Medicaid or Denali Kid Care Number
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	

Income and Insurance Information

Employment Status: Full time Part Time Self Employed Unemployed Student

Do you have Insurance? ☐ Yes ☐ No Do you need assistance in signing up for insurance or Medicaid? ☐ Yes ☐ No

Client's Medicare Number : Eligibility Date:

Primary Insurance Company Name: Policy Number:

Secondary Insurance Company Name: Policy Number:

You will need a copy of your insurance card to complete registration

Total Gross Household Income : $ Is this amount received Weekly Monthly Yearly

Number in Household (including yourself) #

How many people in your household qualified for the Alaska Permanent Fund Dividend this year?

Full name of individual responsible for payment:

Phone: Address:

We will need proof of income to determine if you qualify for our sliding fee discount program

The above information is true to the best of my knowledge. This registration form must be completed in its entirety.

_____ _____

Client/Guardian Signature Date