PROVIDENCE KODIAK ISLAND MEDICAL CENTER
Patient Registration Information

DATE _____ **TIME** _____

PATIENT INFORMATION

NAME _____ DATE OF BIRTH _____
MAILING ADDRESS _____
RESIDENCE ADDRESS _____
HOME PHONE _____
SOCIAL SECURITY # _____ RELIGION _____ SEX _____
MARITAL STATUS _____ NATIONALITY _____ SMOKER ? _____
MEDICAL ALLERGIES _____ LIVING WILL? Y☐ N☐

MILITARY INFORMATION ACTIVE DUTY _____ DEPENDANT _____ VETERAN _____

SPOUSE INFORMATION

SPOUSE NAME _____
SPOUSES EMPLOYER _____ WORK PHONE _____

GUARANTOR (PERSON RESPONSIBLE FOR BILL)

NAME _____ SOCIAL SECURITY # _____
ADDRESS **(IF DIFFERENT THAN PATIENT)** _____
EMPLOYER _____
WORK PHONE _____ HOME PHONE _____

INSURANCE INFORMATION (PRIMARY)

NAME OF CARDHOLDER _____
INSURANCE COMPANY _____
POLICY # _____ GROUP # _____
EMPLOYER _____ OCCUPATION _____
DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION (SECONDARY)

NAME OF CARDHOLDER _____
INSURANCE COMPANY _____
POLICY # _____ GROUP # _____
EMPLOYER _____ OCCUPATION _____
DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

ARE YOU ELIGIBLE FOR KANA BENEFITS? _____ **WHO IS YOUR FAMILY DOCTOR** _____

EMERGENCY CONTACT

NAME _____
CITY _____ STATE _____
RELATIONSHIP _____ HOME PHONE _____ WORK PHONE _____

IS THIS A WORK RELATED INJURY? _____

HAS YOUR EMPLOYER BEEN NOTIFIED? _____ DATE OF INJURY/TIME _____