ANCHORAGE PEDIATRIC GROUP

Patient Registration Form

3340 Providence Drive, Suite 500-Building A, Anchorage, AK 99508
T. 907-562-2423 / F. 907-563-1170

Preferred Doctor (circle one): **Dr. Elliott** **Dr. Heimerl** **Dr. Monterrosa**

How did you hear about us? **(Circle one):**
Word of Mouth **Google** **ER Physician** **Facebook/Social Media** **Insurance** **Other: _____**

Patient Name _____ Sex ____ DOB _____

Mailing Address _____ City _____ State ____ Zip _____

Best Phone Number _____ May we leave a detailed medical message? ◯/◯

Patient Cell Number (if applicable) _____

Ethnicity (select one) ◯ Hispanic/Latino ◯ Not Hispanic/Latino

Race(s) (circle all that apply ☐ American Indian or Alaskan Native ☐ Asian
☐ African-American/Black ☐ Caucasian/White
☐ Hawaiian-Native or Other Pacific Islander ☐ Other Race

Language (select one) ☐ English ☐ Spanish Other: _____

Parent/Guardian Information:

Name _____
Email Address _____
Phone # _____
Address _____
SSN _____
Birthdate _____
Relationship _____

Other Parent/Guardian:

Name _____
Email Address _____
Phone # _____
Address _____
SSN _____
Birthdate _____
Relationship _____

Primary Insurance Name _____
Name of Insured/Policy Holder _____ DOB _____
ID# _____ Group# _____ Relationship to Insured _____

Secondary Insurance Name _____
Name of Insured/Policy Holder _____ DOB _____
ID# _____ Group# _____ Relationship to Insured _____

Emergency Contact Person: _____ Phone # _____
Relationship _____

Name _____ Relationship to Patient _____

Signature _____ Date _____

For Office Use ONLY
Staff reviewed: _____ Date scanned to chart: _____

Effective 06/2019, updated 4/2021, updated 09/2021, updated 01/2022, updated 02/2022