FRONTIER HEALTH AND WELLNESS, LLC

Patient Registration Form – Pediatric/Under Guardianship

Date				
Patient Full Legal Name (First, Middle Initial, Last)	Prefix	Suffix	Previous Name(s)/Alias:	
Date of Birth / Age / Sex	Gender Identity	Preferred Pronoun		
School	Grade	Contact Number		

Guardianship (If guardianship is anything other than shared or 50/50 FHW Must had legal documentation on file prior to any appointment)

Parent/Guardian Name (G1): Guardian listed above guardianship status: ☐ Shared ☐ Primary ☐ Sole	Parent/Guardian Name (G2): Guardian listed above guardianship status: ☐ Shared ☐ Primary ☐ Sole
G1 Preferred Phone Number Can we leave a Voicemail? ☐ Yes ☐ No	G2 Preferred Phone Number Can we leave a Voicemail? ☐ Yes ☐ No
G1 Address	G2 Address
City/State/Zip	City/State/Zip
Email	E-Mail

Reason for choosing Frontier Health and Wellness ☐ Recommendation from Family/Friend ☐ Location/Convenience ☐ Referral from Provider ☐ Search Engine ☐ Insurance ☐ Other		
If referred by hospital or provider, please list who:		
Preferred Pharmacy	Address	Contact Number
Emergency Contact	Relationship	Contact Number

Please Do Not Include Information on Denali KidCare, Medicaid, or Medicare - We Do Not Accept These Plans

Financially Responsible Party	Address	Contact Number
Primary Insurance Carrier (Do Not Include Medicaid/DKC/Medicare)	Subscribers Name	
Policy Number/Member ID (Do Not Include Medicaid/DKC/Medicare)	Group Number	
Patients Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4
Secondary Insurance Carrier (Do Not Include Medicaid/DKC/Medicare)	Subscribers Name	
Policy Number/Member ID (Do Not Include Medicaid/DKC/Medicare)	Group Number	
Patients Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4

I certify that my answers are true and complete to the best of my knowledge. I authorize my insurance benefits to be paid directly to my provider. I understand that I am financially responsible for any balance accrued. I also authorize Frontier Health and Wellness and/or its Contracted Providers to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____