FRONTIER HEALTH AND WELLNESS, LLC

Patient Registration Form – Adult

Date			
Patient Full Legal Name (First, Middle Initial, Last)	Prefix	Suffix	Previous Name(s)/Alias:
Previous Name(s):	Date of Birth	Age	Sex
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Other	Preferred Pronoun	Gender Identity	
Patient Preferred Phone Number Can we leave a Voicemail? ☐ Yes ☐ No	E-Mail		
Physical Address	City, State	Zip Code	
Mailing Address	City, State	Zip Code	
Occupation	Employer	Contact Number	

Reason for choosing Frontier Health and Wellness ☐ Recommendation from Family/Friend ☐ Location/Convenience ☐ Referral from Another Provider ☐ Search Engine ☐ Insurance ☐ Other		
If referred by hospital or clinician, 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 (if other than patient)	Address	Contact Number
Primary Insurance Carrier (Do Not Include Medicaid/DKC/Medicare)	Subscribers Name If same, please do not complete the next 2 rows	
Policy Number/Member ID (Do Not Include Medicaid/DKC/Medicare)	Group Number	
Patient's Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4
Secondary Insurance Carrier (Do Not Include Medicaid/DKC/Medicare)	Subscribers Name If same, please do not complete the next 2 rows	
Policy Number/Member ID (Do Not Include Medicaid/DKC/Medicare)	Group Number	
Patient's 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 Signature: _____ Date:_____