ARETE PROVIDER NETWORK
Arete Family Medicine - Anchorage

Patient Registration Form

Name: _____ Date of birth: _____ SSN: _____

Parent/guardian (if applicable): _____ Marital status: _____

Optional: Birth gender: _____ Gender identity: _____ Preferred pronouns: _____

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Hispanic or Latino

☐ Not Hispanic or Latino ☐ Prefer not to answer

Address: _____

Primary phone number: _____ Email: _____

Preferred communication: ☐ Phone ☐ Email ☐ Text Pharmacy: _____

Employer: _____ Occupation: _____

Insurance Information (Primary)

Subscriber: _____ Relationship to subscriber: _____ DoB: _____

Insurance company: _____ Member/Subscriber ID: _____ Group #: _____

Insured's employer (if different from above): _____

Insurance Information (Secondary)

Subscriber: _____ Relationship to subscriber: _____ DoB: _____

Insurance company: _____ Member/Subscriber ID: _____ Group #: _____

Insured's employer (if different from above): _____

Please initial and sign below

_____ *I authorize the release of any medical or other information necessary to process claims.*

_____ *I also request payment of government benefits to be paid directly to AFM-A.*

_____ *I am also responsible for payment of non-covered services.*

_____ *I give permission for Arete Family Medicine-Anchorage to give me medical treatment.*

_____ _____

Signature of patient or parent/guardian Date