Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

Pediatric Cardiology of Alaska

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Patient Label here

Today's Date _____
Time Arrived _____

Registration Form

Welcome to *Seattle Children's Pediatric Cardiology of Alaska*. Please fill out this form to facilitate the registration process.

Has your child ever been to any clinic or department associated with Seattle Children's Hospital? Y or N

Patient's Last Name: _____ First Name: _____ Middle Name: _____

Mailing Address: _____City: _____

State: _____ Zip Code: _____ Home Phone: (_____) _____ - _____ Alt Phone: (_____) _____ - _____

Birthdate: _____ Birthplace (City/St): _____ Sex: M F Ethnicity: _____

Race: _____ Language: _____ Need an Interpreter? Y or N

Father's Name: _____ Legal Guardian? Y or N Lives With? Y or N

Mother's Name: _____ Legal Guardian? Y or N Lives With? Y or N

Guarantor (if patient is under 18 must be completed):

Guarantor is **(circle one)**: Mother above Father above Other

_____ Relationship to Patient: _____
Last, First

_____
Mailing Address (if different from patient) City State Zip Code

Birthdate: _____ Sex: M F (_____) _____ - _____ (_____) _____ - _____
Home phone with area code Alternate phone (i.e. cell or work)

Social Security Number of Guarantor (unless guarantor is an agency): ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Patient's Primary Physician Name: _____ Name of Clinic (if applicable): _____

Primary Insurance: _____ **Subscriber**: _____ **Subscriber Sex**: M F

Policy #: _____ **Group #**: _____ **Subscriber Birthdate**: _____
(please give insurance card to the registration person)

Insurance Address _____ City _____

State _____ Zip_____ Phone: _____

Secondary Insurance: _____ Subscriber: _____Subscriber Sex: M F

Policy #: _____ Group #: _____ Subscriber Birthdate: _____
(please give insurance card to the registration person)

Insurance Address _____ City _____

State _____ Zip_____ Phone: _____