Iliuliuk Family and Health Services, Inc.
PO Box 144 / 34 Lavelle Ct
Unalaska, AK 99685
(907)581-1202 | ifhs.org

NEW PATIENT REGISTRATION

PATIENT INFORMATION

NAME (Last, First, Middle)	SUFFIX	SSN	DATE OF BIRTH	SEX ☐ M ☐ F	PREFERRED NAME

MAILING ADDRESS	EMPLOYMENT STATUS ☐ Employed ☐ Self-employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Part-time Student ☐ Full-time Student
CITY, STATE, ZIP	EMPLOYER
HOME PHONE / MOBILE	ADDRESS
EMAIL ADDRESS / PRIMARY CARE PHYSICIAN	CITY, STATE, ZIP
EMERGENCY CONTACT NAME (Last, First, Middle) / RELATIONSHIP TO PATIENT	OCCUPATION / WORK PHONE
MAILING ADDRESS	SEXUAL ORIENTATION ☐ Straight (not lesbian or gay) ☐ Lesbian or Gay ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose not to disclose
CITY, STATE, ZIP	GENDER IDENTITY ☐ Male ☐ Female ☐ Transgender Female ☐ Other ☐ Transgender Male ☐ Choose not to disclose
PHONE NUMBER / ALTERNATE PHONE NUMBER	DEAF/HARD OF HEARING ☐ Yes ☐ No / BLIND/LOW VISION ☐ Yes ☐ No / DISABLED ☐ Yes ☐ No

UDS INFORMATION

HOUSING STATUS
☐ Not Homeless ☐ Homeless/Street/Car ☐ Homeless Shelter
☐ Doubling Up ☐ Renting ☐ Owning
☐ Transitional ☐ Public Housing ☐ Other

VETERAN STATUS
☐ Yes
☐ No

AGRICULTURAL WORKER STATUS
☐ Migrant ☐ Not an Agricultural Worker
☐ Seasonal ☐ Unknown

INTERPRETER REQUIRED?
☐ Yes ☐ No

PRIMARY LANGUAGE

RELIGION

MARITAL STATUS
☐ Single ☐ Divorced ☐ Legally Separated ☐ Significant Other
☐ Married ☐ Widowed ☐ Other ☐ Choose not to disclose

ETHNICITY
☐ Latino/Hispanic ☐ Not Latino/Hispanic ☐ Choose not to disclose

RACE
☐ Black/African American ☐ Asian
☐ Alaska Native/American Indian ☐ White/Caucasian
☐ Native Hawaiian/Pacific Islander ☐ Unknown
☐ Other ____________ ☐ Choose not to disclose

OF PEOPLE IN HOUSEHOLD (Adult+Children)

YEARLY HOUSEHOLD INCOME $

We are required to ask the question above. If you do not want to answer one of the questions, please check "Choose not to disclose"

GUARANTOR INFORMATION

GUARANTOR NAME	RELATIONSHIP TO PATIENT	
MAILING ADDRESS		
PHONE NUMBER	SOCIAL SECURITY NUMBER	DATE OF BIRTH

PRIMARY INSURANCE

SUBSCRIBER NAME	SUBSCRIBER SSN
PLAN CARRIER/INSURANCE COMPANY	SUBSCRIBER BIRTHDATE
SUBSCRIBER ID NUMBER	GROUP NUMBER
CLAIM ADDRESS	

SECONDARY INSURANCE (If Applicable)

SUBSCRIBER NAME	SUBSCRIBER SSN
PLAN CARRIER/INSURANCE COMPANY	SUBSCRIBER BIRTHDATE
SUBSCRIBER ID NUMBER	GROUP NUMBER
CLAIM ADDRESS	