



Mat-Su Health Services, Inc

1363 W. Spruce Avenue – Wasilla, AK 99654
(907) 376-2411 (phone) – (907) 352-3363 (fax)

www.mshsak.org

CLIENT/PATIENT INFORMATION

Full Legal Name:		Social Security #:	Date of Birth:		
Are you legally disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
Physical Address (not PO box):		Mailing Address: <input type="checkbox"/> Same as physical			
City:	State:	Zip:	City:	State:	Zip:
Phone:	Alternate phone:	Hispanic/Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> More than one race					
What is your preferred language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Other: _____					
Do you use an interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Where did you hear about us:					

Guarantor/RESPONSIBLE PARTY INFORMATION

Full Name:	Relationship to client/patient:			
Address:	Social Security Number:	Date of Birth:		
City:	State:	Zip:	Phone Number:	Alternate Phone:

Primary Insurance (Provide Card)

Insured Party: <input type="checkbox"/> Same as Patient or <input type="checkbox"/> Same as Guarantor or:	Relationship to client/patient:	
ID Number:	Insured Social Security Number:	
Insurance Company:	Insured Phone #:	Insured Date of Birth:

Emergency Contact

Name:	Relationship to client/patient:
Phone:	

Financial Information

How will you be paying for your visits: Self-pay Medicaid coupons Insurance Other _____

Are you interested in applying for a Sliding Scale Discount? Yes No, I decline the sliding discount

I confirm that the information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____