Ft Thompson IHS #_____

PATIENT REGISTRATION INFORMATION

In order for the Ft. Thompson Indian Health Center to continue providing efficient health services to you and your family, we must update your demographic information at every visit. This statistical information assists the Indian Health Center in providing a variety of services to you. If you have any questions please ask the Patient Registration Clerk or Patient Benefits coordinator for assistance.

Patient Information:

Last Name	First Name	Middle Name	Date of Birth	Social Security Number

Birth Place – City and State	Male or Female	Current Community	Date Moved There

Marital Status	ALIAS Used (name)	Religious Preference

Physical & Mailing Address – City, State Zip Code	Home Phone #	Work Phone #	Cell or Message Phone #

Name of Tribe	Blood Quantum	Tribal Enrollment #

** If you do not have your Tribal Enrollment Card/Paper with you, you will need to sign a 30 day Notice **

** If you are not enrolled with any Tribe you must show proof that you are a Tribal Descendant**

Parent Information: ***Please write DEC - Behind Name if Deceased***

Father's Name_____ Mother's Name_____

Father's Place of Birth _____ Mother's Place of Birth_____

Father's Phone #_____ Mother's Phone #_____

Father's Email Address _____ Mother's Email Address_____

Mother's Maiden Name_____

Employer Information: ***If Minor Child – Please write Parent/Guardian Employer Info***

Employer Name_____ Address_____

Employer Phone #_____ _____

Full Time/Part Time/Seasonal (circle one)

Spouse Employer Name_____ Address_____

Spouse Employer Phone #_____ _____

Full Time/Part Time/Seasonal (Circle one)

Emergency Contact Information:

Name_____

Address_____

_____

Phone #_____ 2nd Phone #_____

Relationship To You_____

Next of Kin Information: *Must be a relative*

Name_____

Address_____

_____

Phone #_____ 2nd Phone #_____

Relationship To You_____

Alternate Resource Information:

** This information is necessary for billing and other resources such as MEDICAID or other Health Insurance **

** Insurance is billed directly to the carrier and not to you as the patient **

Are you covered by MEDICAID? Yes No PLEASE SUBMIT CARD FOR FILE
If Yes, ID #_____ (Brown Card)

Are you covered by MEDICARE? Yes No PLEASE SUBMIT CARD FOR FILE
If Yes, ID #_____ (White Card with Red & Blue Stripe)

Are you covered by Private Health Insurance? Yes No PLEASE SUBMIT CARD FOR FILE
If Yes, ID #_____

Name of Insurance Company_____ Effective Date_____

Group #_____

Name(S) of all insured_____

Veteran Information:

Are you a Veteran? Yes No If Yes, what was your Serial Number_____

Branch of Service_____ Entry Date_____ Discharge Date_____

Vietnam Connected? Yes No Service Connected Disability? Yes No

Other Patient Data:

What Race are you? (Circle one) American Indian or Alaska Native/Asian/African American/White/Other
Are you Hispanic or Latino? Yes No Unknown
What is your Primary Language? Do you need an Interpreter? Yes No
What is your Preferred Language?
Do you have access to the Internet? Yes No If Yes, Where?
Do you have an Email address? Yes No
If yes, what is your email address? _____
What is your Preferred Method of Contact? (Circle one) Mail Email Phone

** You should have received a NOTICE OF PRIVACY PRACTICES, ASSIGNMENT OF BENEFITS FORM, and DIRECT CARE/CHS INFORMATION FORM for you to sign and date. This information will be electronically filed into our database as well as a hard copy placed in your chart. Please Note that all the information you have given is CONFIDENTIAL and will be used only for your continued Health Care. Thank you for your cooperation **

Interview Information:

WAS YOUR INTERVIEW WITH PATIENT REGISTRATION IN A FRIENDLY MANNER?	YES	NO
DO YOU FEEL SECURE THAT YOUR RIGHTS AS A PATIENT ARE RESPECTED?	YES	NO
DO YOU FEEL YOUR RIGHTS TO PRIVACY, AS A PATIENT, ARE RESPECTED?	YES	NO

PATIENT or PARENT/GUARDIAN SIGNATURE_____ DATE_____

** THIS CONCLUDES THE PATIENT REGISTRATION PROCESS. PLEASE REVIEW THIS DOCUMENT TO MAKE SURE THAT YOU HAVE FILLED IT OUT COMPLETELY **

THANK YOU

This section to be completed by Patient Registration Staff:

DATE RECEIVED: _____ STAFF INITIALS: _____

DATE ENTERED: _____ STAFF INITIALS: _____