PATIENT REGISTRATION

HRN:______________

Name:____ DOB:______________
First Middle Last

Birthplace:_____________________________ SS#:____________________ Male:___ Female:____
City/State

Marital Status: Single____ Married_____ Widow/Widower____ Divorced____ Separated_____

Mailing Address:____
Street Address/P.O. Box City State Zip

Location of Home:____
If Different from Above

Home Phone:____________ Cell #:___________ Work #:___________ Message #:___________

E-mail Address:__________________________________ Religious Preference:______________

TRIBAL INFORMATION: You Must Provide Proof of Enrollment/Descendancy to a Federally Recognized Tribe.

Tribe of Membership:_____________________________ Enrolled/Descendant (circle one)

Tribe Quantum:________ Indian Blood Quantum:________ Enrollment #:_______________

Father's Name:______________________________________ Birthplace:_________________
First Last City/State

Mother's Maiden Name:_______________________________ Birthplace:_________________
First Last City/State

Father's Phone #:__________________________ Mother's Phone #:______________________

Father's Employer:_________________________ Mother's Employer:_____________________

Father's E-mail Address:___________________ Mother's E-mail Address:______________

Employer Name:____

Employer Address & Phone:____

Spouse's Employer Name:____

Spouse's Employer Address:_______________________________ Employer Phone:___________

Emergency Contact:____ EC Phone:______________

Emergency Contact Address:____________________________ Relationship to EC:__________
City/State/Zip

Next of Kin:____ NOK Phone:_____________

NOK Address:____ Relationship to NOK:__________
City/State/Zip

Insurance Information (Check All that Apply): **Medicaid:____ Medicare:____ Railroad:____**

*****Please present Insurance Card & complete the reverse side of form***** **Private Insurance:____ Other:____ None:____**

Are You a Veteran? Yes___ No___ If you answered Yes, what Branch?__________________

Entry Date:____________ Separation Date:____________ Vietnam Service Indicated? Yes___ No___

Service Connected? Yes___ No___ Valid VA Card? Yes___ No___

Description of VA Disability:____

Please Read the Following Before Signing Below:

Privacy Act of 1974, Public Law 93-579: I understand that the Information given by me and/or collected is necessary for the Indian Health Service to provide services for my health care and well being. Furthermore, I have been informed that my record shall not be disclosed to any other agency or person without my signed consent. I certify the above information is correct to the best of my knowledge.

____ ____________________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN (if patient is a minor) **DATE**

Ethnicity: Are you Hispanic or Latino? Yes_____ No_____

Primary Language Spoken:______________________________

Other Language Spoken:____________________ Preferred Language:____________________

Are You a Migrant Worker? Yes_____ No_____ Are You Homeless? Yes_____ No_____

Complete the following if you have Private Insurance, Workman's Comp, or Motor Vehicle Accident Insurance

Name of Insurance Company:______________________________

Address of Insurance Company:______________________________

Phone # of Insurance Company:____________________ Policy/Claim #:____________________

Policy Effective Date:____________________ Policy Term Date:____________________

Name of Policy Holder:______________________________

Policy Holder Date of Birth:____________________ SS#:____________________

Policy Holder Employer Name:______________________________

Employer Address:____________________ Phone #:____________________

Other Policy Members	Relationship to Policyholder	Date of Birth

MEDICARE ONLY: Please present your card and complete the following:

Name:______________________________ Medicare #:____________________
(As Shown on Card)

Part A: Yes___ No___ Effective Date:__________ Part B: Yes___ No___ Effective Date:__________

Medicare D (Prescription Drug Coverage): Yes___ No___ Plan Name:____________________

If you have Insurance:

The Indian Health Service may disclose information from my medical record to the Insurance Corporation, which is or may be liable for all or part of the medical services and supplies provided by the Indian Health Service. I hereby assign the Indian Health Service such insurance benefits that I may have pertaining to payment for medical services and supplies furnished by Indian Health Service. I authorize such benefits directly to the Indian Health Service.

STATE OF PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER:

I request that the payment of authorized Medicare benefits be made on my behalf to Indian Health Service Clinic/Hospital for any services furnished to me by this facility and attending physicians. I have also authorized any holder of needed medical information, pertaining to me, be released to the Montana Medical Foundation for Medical Care and its agents, to determine these benefits or the benefits payable to related services. This authorization shall cover inpatient and outpatient visits, clinic, and/or hospital.

______________________________ ____________________

POLICY HOLDER'S SIGNATURE DATE