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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Services Hospital
Little Shell Service Unit
Great Falls, Mt 59404

PATIENT: ____ CHART: ___________

BASIS FOR ENTITLEMENT TO MEDICARE: ___ AGE ___DISABILITY
___ END STAGE RENAL DISEASE

ARE YOU CURRENTLY EMPLOYED? ____ YES ____ NO

IS THIS ILLNESS/INJURY DUE TO AN ACCIDENT (AUTO)? ____ YES ____ NO

IS THE VISIT PAYABLE TO WORKERS COMPENSATION INSURANCE? ____YES ____ NO

DO YOU HAVE A VA FEE SERVICE CARD? ____YES ____NO

DO YOU HAVE BLACK LUNG DISEASE? ____YES ____NO

PATIENT SIGNATURE: ____ DATE: ___________

PATIENT UNABLE TO SIGN (REASON): ____

____

(EXAMPLES: NURSING HOME PATIENT, MEDICAL CONDITION, OR INJURY)

EMPLOYEES SIGNATURE: ____________________________________ DATE: ____________