PATIENT REGISTRATION AND INFORMATION

PATIENT INFORMATION

Patient Last Name:	First Name:	Preferred Name:	Middle Name

Suffix (Jr, Sr., II, etc.)	Sex (Circle One) Male Female	Date of Birth:	Social Security Number:

Address	City	State	Zip Code:

Home Phone	Work Phone	Patient Email:

Cell Phone	Consent to text (Circle One) Yes No	Patient Portal Access Circle One Yes No	Contact Preference (Circle One) Phone Mail Portal

Preferred Language (Circle One):
English Spanish Other:_____ Decline

Marital Status (Circle One): Single Married Divorced Widowed Separated Partner Decline

Race (Circle One):
American Indian African American Islander White Other_____ Decline

Indian Blood Quantum (IF APPLICABLE): | Tribe of Membership

Ethnicity (Circle One) :
Not Hispanic/Latino Hispanic/Latino Other_____ Decline

Live on Reservation Yes No Tribal Enrollment Number:

Family Size: _____

Estimated Income_____
(Circle One): Annual Monthly Bi-weekly, Weekly

Agriculture Worker:	Yes	No	Decline
Homeless:	Yes	No	Decline
School Based Health Center Patient	Yes	No	Decline
Veteran Status	Yes	No	Decline
Public Housing Patient	Yes	No	Decline

Sexual Orientation (Select One)
Lesbian/Gay/Homosexual Straight/Heterosexual Bisexual Choose not to Disclose

Gender Identity (Select One)
Male Female Transgender Gender Queer Choose not to Disclose

Employer Name	Employer City	Employer State	Employer Zip Code:

Occupation:

Employment Status (Circle One): Full-Time Part-Time Act. Military Retired Self Unemployed

GUARDIAN & EMERGENCY CONTACT INFORMATION

Legal Guardian Last Name (if applicable):	Guardian First Name	Guardian Middle Name

Emergency Contact: Name:

Next of Kin Name:

Relationship

Phone:

Next of Kin Relationship (Circle One):
Spouse Parent Child Sibling Fiend Cousin Guardian Other

INSURANCE INFORMATION - PLEASE PROVIDE COPY OF CURRENT INSURANCE CARD

TYPE OF PRIMARY COVERAGE MEDICAID MEDICARE PRIVATE INSURANCE NONE OTHER		
Primary Insurance Company	Effective Date	Expiration Date
Primary Policy Holder Name	Member ID	Group Number:
Patient's relationship to policyholder (Circle One) Husband Wife Self Parent Grandparent Guardian		

TYPE OF SECONDARY COVERAGE (IF APPLICABLE) MEDICAID MEDICARE PRIVATE INSURANCE NONE OTHER		
Secondary Insurance Company (If Applicable)	Effective Date	Expiration Date
Policy Holder Name	Member ID	Group Number:
Patient's relationship to policyholder (Circle One) Husband Wife Self Parent Grandparent Guardian		

AUTOMATIC NOTIFICATION PREFERENCE

I would like to be contacted through automatic messages for the following (Circle all that apply):

Health Notifications: Email Phone Text Message

Appointments: Email Phone Text Message

Announcements: Email Phone Text Message

Billing: Email Phone Text Message

I don't want to be contacted for automatic messaging_____(Please Initial)

I, the undersigned, certify that the information contained on this form is correct to the best of my knowledge. Furthermore, I authorize the release of any health information necessary to process the claim for treatment, payment, or operations. I authorize payment of benefits to Paiute Indian Tribe of Utah, provider or suppliers for services. I assign my insurance benefits be paid directly to the Paiute Indian Tribe of Utah. I hereby authorize the provider and whomever else he/she may designate as his/her assistant(s), to administer those treatments and procedures which in his/her opinion are deemed necessary. I hereby agree, regardless of insurance coverage, that I am responsible for all charges incurred. Payment is expected at the time of service. We will bill your insurance as a courtesy

_____ _____

PATIENTS OR LEGAL GUARDIAN SIGNATURE Date

If patient is a minor, must be signed by guardian listed on application

PATIENT REGISTRATION FORM MUST BE COMPLETED IN FULL TO BE SEEN BY A PROVIDER, NO EXCEPTIONS

	Yes	No	Unsure
AIDS/HIV	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Artificial Joints	☐	☐	☐
Asthma	☐	☐	☐
Blood Disease	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Dizziness	☐	☐	☐
Epilepsy	☐	☐	☐
Excessive Bleeding	☐	☐	☐
Fainting	☐	☐	☐
Glaucoma	☐	☐	☐
Growths	☐	☐	☐
Hay Fever	☐	☐	☐
Head Injuries	☐	☐	☐
Heart Disease	☐	☐	☐
Heart Murmur	☐	☐	☐
Hepatitis	☐	☐	☐
High Blood Pressure	☐	☐	☐
Jaundice	☐	☐	☐
Kidney Disease	☐	☐	☐
Liver Disease	☐	☐	☐
Mental Disorders	☐	☐	☐
Nervous Disorders	☐	☐	☐
Pacemaker	☐	☐	☐
Radiation Treatment	☐	☐	☐
	Yes	No	Unsure
Respiratory Problems	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Rheumatism	☐	☐	☐
Sinus Problems	☐	☐	☐
Stomach Problems	☐	☐	☐
Stroke	☐	☐	☐

Thyroid Disease	☐	☐	☐
Tuberculosis	☐	☐	☐
Tumors	☐	☐	☐
Ulcers	☐	☐	☐
Venereal Disease	☐	☐	☐
Codeine Allergy	☐	☐	☐
Penicillin Allergy	☐	☐	☐
Any other Allergies	☐	☐	☐
(metals, latex, or any other drugs, foods, or medications.)			
Congenital Heart Disease	☐	☐	☐
Chest Pain	☐	☐	☐
Cold Sores	☐	☐	☐
Sexually Transmitted Disease(syphilis, gonorrhea, herpes, etc)	☐	☐	☐
Complications after Dental treatment	☐	☐	☐
Have you been admitted to a hospital or needed emergency care during the past two years?	☐	☐	☐

Other_____

Do you presently, or have you ever…

	Yes	No	Unsure
Used Tobacco	☐	☐	☐

If yes, what type,how much, and for how long?_____

Used Alcoholic Beverages	☐	☐	☐
Used Recreational or Street drugs	☐	☐	☐
Taken Fosamax or any Medication for osteoporosis	☐	☐	☐
Taken Phen-fen	☐	☐	☐

Are you currently taking, or have you taken within the past two years, any prescription or non-prescription drugs? If so, please list:

_____

_____

Women

	Yes	No	Unsure
Are you Pregnant now?	☐	☐	☐

If yes, due date_____

Are you currently using a prescription – type contraceptive?

☐	☐	☐

All health history answers have been answered and are current.

Signature:_____

Signature (Reviewing Doctor):_____

FourPoints Health Dental

Consent Form

I authorize any FourPoints Health provider and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangements and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatment.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventive such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen or Bisphosphonate osteoporosis medication (such as Fosamax, Boniva, Actonel, etc.).

I have been informed about what the sliding scale is, and whether I qualify or not. I understand that I need to provide the required documentation to maintain eligibility. I understand the procedures that qualify for the nominal fee, and that I am able to take advantage of non-covered procedures at a discounted rate.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Signature _____ Date:_____

Witness Signature_____ Date:_____