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:	Consent to text (circle one) Yes No	Patient Portal Access (circle one) Yes No	Contact Preference (circle one) Phone Text Email

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: _____ Annual Monthly Biweekly Weekly

Estimated Income: _____

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

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

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:	Guardian First Name:	Guardian Phone:

Emergency Contact Name:	Next of Kin Name:
Emergency Contact Relationship:	Next of Kin Relationship:
Emergency Contact Phone:	Next of Kin Phone:

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
Billing: Email Phone Text Message
I don't want to be contacted for automatic messaging_____ (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.

_____ _____

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	□	□	□
Respiratory Problems	□	□	□
Rheumatic Fever	□	□	□
Rheumatism	□	□	□
Sinus Problems	□	□	□
Stomach Problems	□	□	□
Stroke	□	□	□
Thyroid Disease	□	□	□
Tuberculosis	□	□	□
Tumors	□	□	□
Ulcers	□	□	□
Venereal Disease	□	□	□
Congenital Heart Disease	□	□	□
Chest pain	□	□	□

	Yes	No	Unsure
Codeine Allergy	□	□	□
Penicillin Allergy	□	□	□
Any other Allergies (metals, latex, other drugs, food, or medications)	□	□	□

Allergy:_____

Cold Sores	□	□	□
Sexually Transmitted Disease (syphilis, gonorrhea, herpes, etc.)	□	□	□

Do you presently or have you ever…

Used Tobacco	□	□	□
If yes, for how long? _____			
Used Alcoholic Beverages	□	□	□
Used Recreational or Street Drugs	□	□	□
Taken Fosamax or any med for osteoporosis	□	□	□
Taken Phen-fen	□	□	□

Women

	Yes	No	Unsure
Are you Pregnant now?	☐	☐	☐
If yes, due date_____			
Are you currently using a prescription – type contraceptive?	☐	☐	☐

Are you currently taking, or have you taken within the past 2 years, any prescription or non- prescription drug? If so, please list:

_____

_____

_____

	Yes	No	Unsure
Complications after dental treatment	☐	☐	☐
Have you been admitted to a hospital or needed emergency care during the past two years?	☐	☐	☐

Other_____

All health history answers have been answered and are current.

Signature: _____

Signature (Reviewing Doctor): _____