San Diego American Indian HEALTH CENTER

HRN _____

Received By: _____

Date Entered:

Patient Registration Form

PLEASE PRINT CLEARLY Date_____/_____/_____

Patient's Legal Name: _____

AKA (also known as): _____PCP (Primary Care Provider): _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Female-to- Male ☐ Transgender Female/Male-to-Female

☐ Other ☐ Chose not to disclose

Home Address: _____

Mailing Address (If different than home):_____

City/State/Zip Code: _____

Home Phone#: _____Daytime/Cell Phone#: _____Work Phone#: _____Ext#: _____

Can we leave a message on the above phone numbers? ☐ Yes ☐ No

Employer Name: _____Occupation: _____

Employer Address: _____ City/State/Zip Code: _____

☐ Full Time ☐ Part Time

Internet Access: ☐ Yes ☐ No If YES, Where? ☐ Home ☐ Work ☐ E-mail Address: _____

Preferred Method of Communication: ☐ Phone ☐ E-Mail ☐ Mail ***FEMALES ONLY: ARE YOU PREGNANT?** ☐ **Yes** **No** ☐

Race: (Select one)

☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander

☐ Asian ☐ White

☐ Black/African American

Ethnicity: (Select one)

☐ Hispanic or Latino Origin

☐ NOT Hispanic or Latino Origin

If American Indian/Alaskan Native:

Tribe: _____ Enrollment #: _____

Indian Blood Quantum: _____

If you are not American Indian/Alaskan Native, are you a member of an Indian household?

☐ Yes ☐ No

Is Patient a US Veteran?

☐ Yes ☐ No

If yes, Branch: _____

Separation Date: _____

Vietnam Vet: ☐ Yes ☐ No

Person Responsible for Patient's Financial Obligation, If Self, Please Indicate:

Name: _____ Relationship: _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Home Phone#: _____ Daytime/Cell Phone#: _____

Work Phone#: _____ Ext#: _____

(If Different from Patient's address)

Home Address: _____

City/State/Zip Code: _____

Employer Name: _____City/State/Zip Code: _____

Please complete reverse side

San Diego American Indian HEALTH CENTER

Patient Registration Form

In Case of Emergency – Name of Relative NOT living with you

Primary Contact Name: _____ Relationship: _____

Home Phone#: _____ Work Phone_____ Ext: _____

Home Address: _____ City/State/Zip Code: _____

Secondary Contact Name: _____ Relationship: _____

Home Phone#: _____ Work Phone_____ Ext: _____

Home Address: _____ City/State/Zip Code: _____

As a Federally Qualified Health Center, SDAIHC is required to report the following information for the population we serve:

Number of People in Household (Immediate family ***only***) _____ Household Income (Monthly) _____

Primary Language: _____ Preferred Language: _____

Interpreter Required: ☐ Yes ☐ No

Other Language: _____ English Proficiency: ☐ Not at All ☐ Not Well ☐ Well ☐ Very Well

Migrant Worker: ☐ Yes ☐ No Homeless: ☐ Yes ☐ No

Sexual Orientation: ☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Something else ☐ Don't know ☐ Chose not to disclose

FOR MINOR PATIENTS:

Father's Name: _____ SSN: _____-_____-_____ DOB _____/_____/_____

Employer Name: _____ City/State/Zip Code: _____

Mother's Name: _____SSN: _____-_____-_____ DOB _____/_____/_____

Employer Name: _____ City/State/Zip Code: _____

In addition to myself, I authorize the following individuals to consent for Medical/Dental care for (circle one) me or my child:

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

I hereby authorize Medical /Dental Treatment for the above patient.

Signature: _____

Date: _____

Print Name (If Parent or Guardian) _____

Relationship: _____

Please complete reverse side

San Diego American Indian HEALTH CENTER

Insurance Information

PLEASE PRINT CLEARLY Date_____/_____/_____

Patient's Legal Name: _____ DOB: _____/_____/_____

Does the patient have health insurance? ☐ Yes ☐ No

Medical Insurance

Medicare Name: _____ Medicare ID#: _____

Issue Date: _____ ☐ Part A ☐ Part B ☐ Part D

Medi-Cal Name: _____ Medi-Cal ID#: _____

Issue Date: _____

Medi-Cal Managed Care Plan: _____ Member ID#: _____

Primary Insurance

Insurance Co: _____

Insurance Phone#: _____

Subscriber: _____

Subscriber's Employer: _____

Subscriber's DOB: _____

Subscriber's SSN: _____

Policy #: _____

Group #: _____

Effective Date: _____

Secondary Insurance

Insurance Co: _____

Insurance Phone#: _____

Subscriber: _____

Subscriber's Employer: _____

Subscriber's DOB: _____

Subscriber's SSN: _____

Policy #: _____

Group #: _____

Effective Date: _____

Dental Insurance

Insurance Co: _____

Insurance Phone#: _____

Subscriber: _____

Subscriber's Employer: _____

Subscriber's DOB: _____

Subscriber's SSN: _____

Policy #: _____

Group #: _____

Effective Date: _____

Please complete reverse side

Insurance Information

San Diego American Indian HEALTH CENTER

Assignment of Benefits
By signing below:

- I, the undersigned, hereby authorize assignments of and direct billing to Medi-Cal, Medicare and/or any other insurance benefits to San Diego American Indian Health Center for services provided to the patient.
- I further agree and acknowledge that my signature on this document authorizes San Diego American Indian Health Center to obtain and release any medical/dental/behavioral and billing information to Medi-Cal, Medicare and/or any other insurance necessary to process my claim(s), including determining eligibility and seeking reimbursement for services provided.
- If my insurance company reimburses me directly instead of San Diego American Indian Health Center, I will submit payment in the same amount to San Diego American Indian Health Center within thirty (30) days on my receipt of the payment.
- I am responsible for notifying San Diego American Indian Health Center within thirty (30) days of my receipt of the payment.
- I am responsible for notifying San Diego American Indian Health Center if there is any change in my insurance, including the addition and/or loss of any insurance coverage. If I fail to notify the clinic of any such changes in insurance, I may be responsible for any charges as a result.
- Lab Work – I have the option of billing my services or paying for the cost of the labs at the time of the visit.
- I understand that I am responsible for the deductible non covered services and any balance due after insurance.
- I understand and waive my right to confidentiality if a collection service or court action becomes necessary to collect my delinquent account.

_____

Name of Responsible Party (Please Print)

Signature of Responsible Party Date

Please complete reverse side

San Diego American Indian
HEALTH CENTER

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received from the San Diego American Indian Health Center a Clinic Services Information brochure. This brochure contains general clinic services information which includes the following:

- Eligibility For Services
- Payment Policy
- Billing Inquiries
- Appointments Policy
- Appointment Cancellation Policy
- Late Arrival Policy
- Missed Dental Appointment Policy
- Medical/Dental/Behavioral Health Services Information
- Patient Rights and Responsibilities
- Other Services
- Notice of Privacy Practices
- Additional Uses of Information
- Dental Material Fact Sheet

_____

Patient Name (Please Print)

_____

Signature Date

Please complete reverse side

San Diego American Indian HEALTH CENTER

Promoting Excellence in Health Care with Respect for Custom and Tradition

GENERAL CONSENT FOR TREATMENT & ASSIGNMENT OF BENEFITS

Patient's Name: _____ Chart Number: _____

1. Consent to Medical, Dental, Psychological, Nursing and Surgical Procedures:
   The undersigned consents to the patient entering SDAIHC identified above and receiving medical, dental, psychological, general duty nursing or surgical procedures, which may include emergency services, laboratory procedures, anesthesia and other procedures under the general and specific instructions of the patient's healthcare provider(s). The undersigned acknowledges that the patient or the legal representative of the patient will be required to sign additional consent forms for complex treatments and procedures which require the patient's provider to obtain informed consent from the patient or the patient's legal representative for such treatment or procedures.

2. Release of Patient Information:
   SDAIHC will not release patient identifiable information to any third party without the patient's written consent, except as permitted or required by law: The undersigned agrees that SDAIHC may release information without a patient consent, to the extent necessary, (1) to insure continued treatment by healthcare providers and (2) to determine who is responsible for payment and to obtain payment or reimbursement for services provided to the patient. Third parties who may receive such information under this paragraph include insurance companies, utilization reviewers, and case managers, federal and state agencies, consulting and treating providers, patient's employer and managed care plans who are responsible for payment of covered services. (Psychological/HIV/AIDS information will require a special consent prior to release).

3. Payment for services:
   I, the undersigned, certify that the information given to SDAIHC in applying for payment by third parties is correct. I hereby authorize payment of benefits on my behalf for services furnished to me, and authorize SDAIHC to release minimum necessary patient health information pertaining to the visit to the Health Care Financing Administration or to the California Department of Health Services or other agents which is necessary to determine benefits or payment for services under these programs.

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____

Patient/Legal Representative

Relationship to Patient: _____

DATE:_____

SDAIHC - ADULT HEALTH HISTORY

Patient Name: _____ **DOB:** _____

My health concern today:

_____

_____

Major Past Illnesses: _____

Recent Hospitalizations or Surgery: _____

Current Medications List

MEDICATION NAME	DOSE / MG	Times per day	MEDICATION NAME	DOSE / MG	FREQUENCY

Allergies (especially medications):_____

Have you recently had any of the following exams?

Electrocardiogram ( ) Yes ( ) No Normal ( ) Yes ( ) No

Tuberculosis Test ( ) Yes ( ) No Normal ( ) Yes ( ) No

Lab Test ( ) Urine ( ) Stool Normal ( ) Yes ( ) No

Habits Tobacco ( ) Alcohol ( ) Drugs ( )

	YOU	YOUR FAMILY	Have you had:	YES	NO
DIABETES	____	____	WEIGHT LOSS	____	____
HIGH BLOOD PRESSURE	____	____	SKIN LESIONS	____	____
HEART DISEASE	____	____	VISUAL PROBLEMS	____	____
TUBERCULOSIS	____	____	FREQUENT COLDS	____	____
SEIZURES	____	____	DENTAL PROBLEMS	____	____
ASTHMA/BRONCHITIS	____	____	HOARSENESS	____	____
CANCER	____	____	BREAST NODULES	____	____
HEPATITIS	____	____	DIFFICULTY BREATHING	____	____
ANEMIA	____	____	PALPITATIONS	____	____
ARTHRITIS	____	____	CHRONIC COUGH	____	____
INTESTINAL PROBLEMS	____	____	CHEST PAIN	____	____
EMOTIONAL PROBLEMS	____	____	SWALLOWING PROBLEMS	____	____
ULCER DISEASE	____	____	DIARRHEA/CONSTIPATION	____	____
THYROID DISEASE	____	____	BLOOD IN STOOL	____	____
SEXUAL INFECTION	____	____	NAUSEA/VOMITING	____	____
GLAUCOMA	____	____	PAIN ON URINATION	____	____
STROKE	____	____	JOINT/BACK PAIN	____	____
RHEUMATIC FEVER	____	____	CHRONIC HEADACHES	____	____
GALLBLADDER STONES	____	____	DIZZY/WEAKNESS	____	____
KIDNEY STONES	____	____	HEARING PROBLEMS	____	____
OTHER PROBLEMS	____	____	SEXUAL CONCERNS	____	____
			SLEEPING PROBLEMS	____	____

FOR WOMEN ONLY:

Last Menstrual Period: _____ Normal? ( ) Yes ( ) No Birth Control Method: _____

PATIENT SIGNATURE: _____

REVIEWED BY: _____ DATE: _____

HRN _____

REC'D BY _____

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

I hereby authorize San Diego American Indian Health Center to speak to the following individuals about my health and health record, including information regarding scheduling, billing and insurance. I understand that this does **not** include protected information regarding HIV, psychiatric, drug and/or alcohol records.

NAME	DATE OF BIRTH	RELATIONSHIP

I understand that I may revoke this authorization at any time in writing.

Patient Name (please print) _____ Date of Birth _____

Patient (Guardian) Signature _____ Date _____

San Diego American Indian Health Center

San Diego American Indian Health Center (SDAIHC)
Medical and Dental Departments

Authorization for Use and Disclosure of Protected Health Information

The privacy of your health information is protected. This form allows us to either send or receive information concerning your health, as detailed below.

I hereby authorize:
Person or organization who will release the health information (include phone and address if known):

☐ _____

☐ SDAIHC, 2630 First Avenue, San Diego, CA 92103 Ph: 619-234-2158 Fax: 619-234-0206

To release information to:
Person or organization who will receive the health information (include phone and address if known)

☐ _____

☐ SDAIHC, 2630 First Avenue, San Diego, CA 92103 Ph: 619-234-2158 Fax: 619-234-0206

Information to be released: The information to be released includes (Check all that apply):

[ ] Entire Record [ ] Immunizations [ ] HIV/AIDS related treatment
[ ] Other (specify) _____ [ ] Alcohol / Substance Abuse
[ ] Psychotherapy Notes (by checking this box, I am waiving any psychotherapist-patient privilege).

Purpose for release of health information:
The information described above is being released for the following reason(s):

_____

Right to terminate or revoke authorization: You may cancel (revoke or terminate) this authorization at any time by submitting a written request to the SDAIHC Medical Records Department.

Potential for re-release (re-disclosure) of information: I understand that once information is released by SDAIHC to the recipient noted above, we can no longer assure that the information will not be released again to a different party by the recipient noted above.

Your rights: You have the right to inspect or copy information that is used or released under this authorization. You also have the right to refuse to sign this authorization. If you refuse to sign this form, it will not prevent SDAIHC from providing you with medical care unless the treatment is research-related or if it is treatment done for the sole purpose of providing the treatment information to another party (for example, having lab work performed as at SDAIHC for a doctor at another clinic).

Patient Name: _____ DOB: _____

_____ Date: _____
Signature of PATIENT

_____ Date: _____
Signature of Patient Representative

_____
Relationship to Patient