MRN:

PATIENT REGISTRATION FORM

Today's Date: _____

How did you hear about us?

[ ] Insurance/CenCal [ ] Family/Friend [ ] Caretaker [ ] Self [ ] Skilled Nursing [ ] Hospital

[ ] Agency:_____ [ ] Referral:_____ [ ] Other: _____

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name:_____ First Name:_____ MI:_____

Social Security#:_____ Date of Birth: _____ Sex at Birth: [ ] M [ ] F

Address: _____ City:_____ State:_____ Zip:_____

Email: _____ Employer: _____

Preferred Pharmacy: _____/_____/_____
Name of Pharmacy City Phone Number

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed **Primary Care Physician Name**: _____

Preferred Language:_____ Do you need an Interpreter? [ ] Yes [ ] No **Religious Preference:** _____

Preferred Method of Communication: [ ] Phone [ ] Text Message [ ] Email [ ] Do Not Notify / Opt-Out

Day Phone: (____) _____ Cell Phone: (____) _____ Home Phone: (____) _____

Best number to reach you: [ ] Day Phone [ ] Cell Phone [ ] Home Phone OK to leave a message? _____

IN CASE OF EMERGENCY

Emergency Contact Name:_____ Phone _____

Address: _____ Relationship: _____

Next of Kin Name:_____ Phone _____

Address: _____ Relationship: _____

RESPONSIBLE PARTY: IF PATIENT IS UNDER AGE 18

Last Name:_____ First Name:_____ MI:_____

Relationship to Patient:_____ *(Present Photo ID so we may make a photocopy)*

Social Security Number:_____ Birthdate (mm/dd/yyyy):_____ Sex: [ ] Male [ ] Female

Address: _____ City:_____ State:_____ Zip:_____

Home Phone :(_____)_____ Cell Phone :(_____)_____ Work Phone:(_____)_____

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FAMILY INFORMATION

Family Size:_____ **Income:**_____ ***Income cycle:*** [ ] Weekly [ ] Monthly [ ] Annually

Mother's Last Name: _____ **First Name:** _____ **Maiden Name:**_____

As a Federally Qualified Health Center and to keep our services affordable, AIH&S receives grant funding. To qualify for these resources we must collect the following information on all our clients. Please support AIH&S by answering all questions.

INSURANCE INFORMATION

Present all current insurance cards so we may make a photocopy

Primary Insurance Coverage: _____

Secondary Insurance Coverage: _____

If you have Private Insurance and are a dependent on someone else's insurance we will need the following:

Policy Holder's Full Name: _____ Date of Birth: _____ Sex _____

Non-Insured Patients: There are programs available for patients whom are uninsured or underinsured. Please contact a front office staff member or call our clinic at (805) 681-7144 for more information.

Do you have an Advance Directive: [ ] Yes [ ] No *If yes, specify name of document*: _____

Are you currently Homeless: [ ] Yes [ ] No *If Yes, please indicate if you are:* [ ] Doubling Up [ ] Shelter

Are you a US Veteran: [ ] Yes [ ] No [ ] Street [ ] Transitional

Are you a Migrant Worker: [ ] Yes [ ] No *If Yes, please indicate if you are:* [ ] Seasonal [ ] Migrant

If you are a member of a Native American or Alaska Native Tribe, please provide the name of the tribe and a copy of your membership documentation. **Specify Name of Tribe(s):** _____

Release of Information / Assignment of Benefits: American Indian Health & Services has my permission to release information as needed for insurance processing and for my insurance to release payment to American Indian Health & services.

I HEREBY AUTHORIZE TREATMENT: I hereby grant authorization and consent for medical treatment for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for.

_____ _____

Signature of Patient or Guardian if patient a Minor Date

_____ _____

Print Patient/Guardian's Name from above Relationship to Patient

Office Use Only: [ ] Toolkit Provided [ ] Verified Patient Information [ ] Collected Photo ID/Insurance Card(s)

Reviewer's Initials: _____ Data Entry Completed by: _____ Date Scanned: _____

MRN:

American Indian Health & Services

Patient Name: _____ Date of Birth: _____

As part of our standard registration process, we ask each patient the questions below to ensure we can respond to your needs in a way that makes you most comfortable. The information collected on this form will help our health care providers to deliver appropriate prevention, screening, and treatment services. Please provide this form to the front office staff. All information will be kept confidential.

Ethnicity

- ☐ Hispanic/Latino
- ☐ Non-Hispanic
- ☐ Unknown
- ☐ Declined to Answer

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Unknown
- ☐ Declined to Answer

Sex Assigned at Birth

What sex were you assigned at birth?

- ☐ Male
- ☐ Female
- ☐ Undifferentiated
- ☐ Decline to Answer

Gender Identity

What is your current gender identity?

- ☐ Male
- ☐ Female
- ☐ Transgender Woman (Male-to-Female)
- ☐ Transgender Man (Female –to-Male)
- ☐ Gender queer
- ☐ Non-Binary, neither male nor female
- ☐ Other
- ☐ Declined to Answer

Sexual Orientation

Do you think of yourself as:

- ☐ Straight/Heterosexual
- ☐ Mostly Heterosexual
- ☐ Bisexual
- ☐ Lesbian, Gay or Homosexual
- ☐ Don't know
- ☐ Other
- ☐ Unknown

Preferred Pronoun

What is your preferred name? _____

What pronoun do you use?

- ☐ He/Him/His
- ☐ She/Her/Hers
- ☐ They/Them/Their
- ☐ Name
- ☐ Unknown
- ☐ Decline to Answer