Patient Registration/Demographics

Southwestern District Health Unit
528 21st St. W
Dickinson, ND 58601

OFFICE USE ONLY- Check if verified

Client's First Name | M.I. | Client's Last Name | Preferred Name/Maiden Name

Client's Date of Birth | Age | Gender (circle one) M F Other | Are you a Veteran? Yes No | Country of Origin

Marital Status:
- Single
- Married
- Separated
- Divorced
- Widowed
- Life Partner
- Common Law Spouse
- Domestic Partner
- Other Status

Race:
- American Indian
- Black
- White
- Other Race:

Ethnicity:
- Hispanic
- Not Hispanic

Language Preferred:
- English
- Spanish
- Other:

Mailing Address | Physical Address

City | State | Zip Code | County

Home Phone | Cell Phone | Work Phone

Primary Care Physician | Phone

Highlight

Do you have private insurance that covers immunizations? Yes No

If you have a secondary insurance please inform the Registration Desk

Primary Insurance Provider:
- Blue Cross Blue Shield #
- Sanford Health Plan #
- ND Medicaid #
- Medicare #
- Railroad Medicare
- Medicare Advantage Plan: Company | Policy # | Last 4 SSN #
- Other:
- No Insurance
- Contract Payer

Please fill out if Policy holder is different than client
- Insurance Policy Subscriber's Name
- Subscriber's Date of Birth
- Subscriber's Address and Phone #

Parent/Emergency Contact Information:
Name | **Relationship** | **Phone**

Below is the updated communications policy. Please check how you prefer to receive appointment confirmation/reminders:
- Text
- Phone
- Email
- English
- Spanish
- Decline

Tobacco Screening	Circle One	
Do you use tobacco (cigarettes, chew, anything combustible, etc.)?	Yes	No
Do you vape or use any other nicotine?	Yes	No
Are you exposed to secondhand smoke?	Yes	No
Advised to quit?	Yes	No
Cessation referral offered?	Yes	No

1. I acknowledge that I have been provided with Southwestern District Health Unit's Notice of Privacy Practices. I understand that I may request an additional copy of this Notice. I agree that I am financially responsible for services provided and not covered by a third-party payer. I assign and authorize any third-party payer to make payment to SWDHU for all benefits that I am eligible for.

2. I authorize the release of any medical or other information necessary to process this claim.

3. The information collected on this form will be used to document authorization to receive vaccinations. Information may be shared through the ND Immunization Information System (NDIIS) with other entities in accordance with ND Century Code 23-01-05.3. A copy of the appropriate Center's for Disease Control & Prevention Vaccine Information Statement(s) has been provided. I have read, or have had explained, the information about the disease(s) and the vaccine(s) listed. I had an opportunity to ask questions which were answered satisfactorily. I understand the benefits and risks of these vaccine(s) and ask that the vaccine(s) listed be given to me or the person named above for whom I am authorized to make this request.

4. I hereby consent and state my preference to have SWDHU and its staff, communicate with me by email, automated calling system or standard SMS messaging regarding my services. I understand that email, automated calling systems and standard SMS messaging are not confidenital methods of communication and my be insecure. I further understand that, because of this, there is a risk that email, automated calls and standard SMS messaging regarding my information might be intercepted and read by a third party. I understand this authorization is voluntary, and SWDHU may not condition services on whether I sign this authorization. This authorization my be revoked by written notice to SWDHU.

Staff Initials

Signature of Client / Parent or Legal Guardian (if under 18) | **Date**