NATIVE PROJECT PATIENT REGISTRATION FORM

Patient Name: _____
(First) (Middle) (Last)
Social Security Number _____-_____-_____Patient's Full Maiden Name: _____
Sex at Birth: □Male □Female

Gender Identity: Check One
□Male □Female □Transgender Man/Transgender Male/Transmasculine □Transgender Woman/Transgender Female/Transfeminine □Genderqueer; Neither Exclusively Male or Female □Other _____ □Chose not to disclose

Sexual Orientation: Check One
□Lesbian or Gay □Heterosexual (or straight) □Bisexual □Other □Don't know □Chose not to disclose

Date of Birth: _____/_____/_____ Are **you multiple birth?** Y/N ***If so, birth order:*** _____
Marriage Status: □Married □Single □Separated □Divorced □Widow
Race: □American Indian/Alaska Native □Asian Indian □Chinese □Filipino □Japanese □Korean □Vietnamese □Other Asian □Native Hawaiian □Other Pacific Islander □Guamanian or Chamorro □Samoan □Black/African American □White □Unreported/Chose not to disclose Race
Ethnicity: □Mexican □Mexican American □Chicano/a □Puerto Rican □Cuban □Another Hispanic, Latino/a or Spanish Origin □Not Hispanic, Latino/a, or Spanish Origin □Unreported/Chose not to disclose Ethnicity
Primary Language:_____Would an interpreter be helpful for you? ( ) Yes ( ) No
Employment Status: Unemployed/Fulltime/Part-time/Self Employed/Retired/Active Military
Employer Name: _____ **Employer Phone:** (____) _____ - _____
Employer Address: _____
(Street) (City/State/Zip)

Patient's Address: _____
(Street) (City/State/Zip)
E-mail Address: _____
Method of Contact (choose one): □Voice □Text □Email
Do we have permission to send generic health information to your email? □Yes □No
Cell Phone: (__) _____ _____ Home Phone: (__) _____ _____ List PCP Name Here:_____
Gross Monthly Income:_____ Number of People in the Household:_____
If under the age of 18: Mother's Maiden Name:_____ Employer_____FT or PT
Father's Name:_____ Employer_____FT or PT
Are you an Indian Child Welfare Recipient involved in foster care? □Yes □No
Would you like to register to vote? □Yes □ No How did you hear about our clinic?

Person responsible for bill or parent (Complete only if different from patient)
Guarantor Name:_____ Social Security Number: _____-_____-_____
Relationship to Patient: (circle) self/spouse/parent/guardian Date of Birth: _____/_____/_____
Employment Status: Unemployed/Fulltime/Part-time/Self Employed/Retired/Active Military
Address:_____ Phone Number:_____
Employer Name:_____ Phone Number:_____
Employer Address:_____
(Street) (City/State/Zip)

First Insurance Information (We MUST have a copy of the front & back of your insurance card)
Name of Insurance:_____ I.D. Number:_____
Address:_____ Group Number:_____
Policy Holder:_____ Effective Date:_____
Policy Holder's Social Security Number _____-_____-_____ Date of Birth:_____
Policy Holder's Address:_____ Phone Number:_____
Second Insurance Information (We MUST have a copy of the front & back of this insurance card)
Name of Insurance:_____ I.D. Number:_____
Address:_____ Group Number:_____
Policy Holder:_____ Effective Date:_____
Policy Holder's Social Security Number _____-_____-_____ Date of Birth:_____
Policy Holder's Address:_____ Phone Number:_____

Who to call for an Emergency:
Relationship:_____ Name:_____ DOB:_____
Address:_____ Home Phone:_____

Are you currently or have you been homeless within the last 12 months? ☐Yes ☐No
If yes: ☐Homeless Shelter ☐Transitional Housing ☐Other ☐Doubling up ☐Living on the Street ☐Permanent Supportive Housing ☐Unknown Zip code:_____
Are you a migrant agricultural worker or season agricultural worker in the past 12 months? ☐Yes ☐No
Veteran: ☐Yes ☐No **Discharged Date:** _____

For AI/AN Descendancy purposes, please list the names of your BIOLOGICAL children/parents:
Parent Names: _____
Children Names: _____

Native American Documentation Information:
Tribe:_____
Enrolled: ☐Yes ☐No If yes, Tribal Enrollment #:_____
Descendent ☐Yes ☐No If yes, please complete the following:
Enrolled Family Member's Name: _____
Relationship to You: _____ Enrollment #: _____

Is your visit due to a job related injury or an auto accident? **Y/N *If YES*, notify a patient services representative**

As a licensed child-serving agency, we are required to ask the following: Have you ever been convicted of a felony? **Y/N**

Have you been convicted of a crime that currently requires you to register with the local police or sheriff's office? **Y/N**

FINANCIAL ASSISTANCE SCREENING: To apply for financial assistance please request a sliding fee application from the front desk. This form must be updated every 12 months OR in the event of change in income or household size to remain eligible for services. You may not be eligible for assistance if this form is not complete, up to date and income is verified with one of our patient services navigator employees.

DISCLOSURES & CONSENTS

THE PRECEDING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

TREATMENT & PAYMENT AGREEMENT FOR SERVICES DONE AT THE NATIVE PROJECT:
I request the NATIVE Project to provide me and/or my dependents with medical, dental or behavioral health care. I acknowledge my responsibility to pay for that care according to the fees established. I understand that I am responsible for any remaining fees my insurance does not pay. I authorize assignment of benefits for medical/dental/behavioral health services to be paid to:

THE NATIVE PROJECT

_____ _____
PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE

I have been given HIPAA's notice of privacy practices, have read and understand my rights.

_____ _____
PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE

Please note, our office has converted to an Electronic Medical Records System called Greenway Intergy and will have the capability of sharing billing & electronic health data with State & Federal business associates as required by law.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I hereby authorize the NATIVE PROJECT to release any of my or my dependent's medical, incidental non-public personal health information that may be necessary for medical/dental/behavioral health evaluation, treatment, consultation, or the processing of insurance benefits.

_____ _____
PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE