UNITED INDIAN HEALTH SERVICES, INC.

Patient Registration

Date of Registration: ______________________ MRN: ______________________

☐ Arcata ☐ Eureka ☐ Weitchpec ☐ Fortuna ☐ Crescent City ☐ Smith River ☐ Klamath ☐ Elk Valley

Section 1: General Information

Last Name:	First & Middle Names:	Previous Names Used:	Birth Sex:	Current Gender:	Birth Date: (mm/dd/yy)
Mailing Address:		City:	State:	Zip:	County
Home Address: (if different than above)		City:	State:	Zip:	County:

If homeless what type: ☐ Doubling up ☐ Shelter ☐ Street ☐ Transitional	**Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Social Security Number:	Previous Address: (City, State, Zip if at current address less than 3 years)
**Home Phone/Landline:	What is your PREFERRED method to receive information: ☐ Phone ☐ Email ☐ Mail
**Cell Phone:	
**Message Phone:	

**Email Address:	Do you have internet access? ☐ Yes ☐ No		Veteran: ☐ Yes
Father's Name: (Last, First, MI)	Date of Birth:	Birth Place: (City, State)	Tribe:
Mother's Maiden Name: (Last, First, MI)	Date of Birth:	Birth Place: (City, State)	Tribe:

Section 2: Race/ Tribe/ Ethnicity

Race: ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Black ☐ White ☐ Multiple races ☐ Other/Unk

American Indian/Alaska Native Tribe:	Tribal Roll Number:	California Roll Number:

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown by Patient ☐ Decline to Answer

Section 3: Insurance— Please present your insurance card when registering

Medicare Number:	Medi-Cal / Partnership Number:		
Insurance Name:	ID Number:	Subscriber:	Relation to Patient:
Insurance Name:	ID Number:	Subscriber:	Relation to Patient:

Section 4: Emergency Contact

Name: (Last, First)	Address: (City, State, Zip)
Telephone Number:	Relationship to Patient:

**** We will use these phone numbers and/or email addresses to communicate with you. If you wish us to use a different number or method, please check this box ☐ and tell us how to contact you____.**

You may change this option at any time.

GENERAL ACKNOWLEDGEMENTS:

1. This clinic is a PRIMARY CARE AGENCY.
2. We will take care of a full range of ambulatory conditions.
3. We MAY NOT BE AVAILABLE AT CERTAIN TIMES, but you can reach the PHYSICIAN through the answering service in an emergency.
4. UIHS does provide professional care to patients requiring hospital care, and we may make referrals for treatment to another doctor, clinic, specialist, laboratory, or support services organization, but **UIHS IS NOT FINANCIALLY RESPONSIBLE FOR ANY MEDICAL, DENTAL, HOSPITAL, LABORATORY FEES, OR ANY OTHER COSTS FOR SERVICES RENDERED OUTSIDE THE UIHS CLINIC.**
5. We provide a comprehensive prenatal program with our physicians delivering and assisting in Caesarean-sections.
6. Upon verification of client's eligible Indian beneficiary status, UIHS adult Indian clients are automatically registered as members of UIHS, Inc., a California nonprofit mutual benefit corporation. Pursuant to UIHS bylaws, a record of members' names and addresses is kept at the corporation's principal office, subject to right of inspection by UIHS directors, and UIHS members may be mailed materials related to the governance of UIHS."

AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the release of this information for the purpose of verification of Indian status and I understand that it will be used to determine eligibility. I am also aware that I am subject to immediate termination of services if the verification process is not completed within a reasonable amount of time as set forth in applicable United Indian Health Services (UIHS) policies. I also authorize a photocopy of this certification to be used, and to be considered as valid as the original.

I also hereby authorize the release of any information, including diagnosis of a medical condition, for the sole purpose of submission of claims to third party billing insurance carriers. I further authorize the UIHS provider to release any information required in the processing of this claim. I hereby assign any insurance benefits to and authorize my insurance benefits to be paid directly to UIHS.

Under penalty of perjury I hereby declare that the information provided on this form is true and correct to the best of my knowledge.

DATE:__________________ **SIGNATURE:** ____________________________________