NHBP Health Department Patient Registration

Complete form in ink **NHBP/ CHS or Direct** **HD Initials** _____ **Date Rec'd** ____/____/____ **HRN #** _____

SECTION 1 PATIENT DEMOGRAPHIC / RELIGION INFORMATION

Patient's Name (Last) (First) (Middle)		Date of Birth (m/d/yr)	Place of Birth (City & State)
Other Names Used (if applicable)	Sex	Social Security #	Marital Status
Physical Address (Number & Street) Mailing Address (if different or PO Box)	City	County	State / Zip Code
Home Phone # ( )	Work Phone # ( )	Cell or Message Phone # ( )	Present Community (city living in):
Is patient enrolled with Huron Potawatomi? □Yes □ No Is enrollment pending? □ Yes □ N Is a descendant of enrolled member? □ Yes □ No Name of Tribe if not Huron Potawatomi:		Enrollment #:	Tribal Blood Quantum: Total Blood Quantum:

SECTION 2 PARENTAL INFORMATION FOR MINORS

Has/Is patient under foster care? If yes, when?	Name of Custodial Parent(s) / Guardian(s) (if applicable)	Phone # (if different from above) ( )	Religion (optional)
Paternal Father's Name (Last, First)		Father's Place of Birth (city & State)	
Father's Email Address:		Father's Cell #:	Alt #:
Maternal Mother's Name (Maiden Last, First)		Place of Birth (city & State)	
Mother's Email Address:		Mother's Cell #:	Alt #:

SECTION 3 PATIENT TRIBAL / EMPLOYER INFORMATION

Patient's Employer Name (if applicable)	Address (City, St, Zip)	□ Full Time □ Part Time	Work Phone #:
Spouse's Employer Name (if applicable)	Address (City, St, Zip)	□ Full Time □ Part Time	Work Phone #:
Father's Employer Name (if applicable)	Address (City, St, Zip)	□ Full Time □ Part Time	Work Phone #:
Mother's Employer Name (if applicable)	Address (City, St, Zip)	□ Full Time □ Part Time	Work Phone #:

SECTION 4 PERMITTED USE OF PROTECTED HEALTH INFORMATION

Please list below an individual who may be given information about your health care or location in case of an emergency or disaster situation.

Additionally, if you permit your NHBP care team to share your health information with other individual(s) involved in your care or payment for you care, please list the individual(s) below.

Name of Emergency Contact / Next-of Kin	Phone # ( )	Relationship (is this individual involved in your care? □Y □N)	
Address (Number & Street)	City	State	Zip Code
Name of Individual Involved in Your Care:	Phone # ( )	Relationship	
Name of Individual Involved in Your Care:	Phone # ( )	Relationship	

SECTION 5 PATIENT INSURANCE INFORMATION

NO INSURANCE □ I do not have any insurance (go to section 7)

MEDICARE (if applicable) Do you have Part A: _____ Part B: _____ Part D: _____		Medicare Number	
MEDICAID (if applicable) Is patient Eligible? □Yes □ No	Eligibility Date	Medicaid State	Medicaid Number
Has applicant applied for Medicaid □ Yes □ No			

PRIVATE INSURANCE A (PRIMARY)

Includes coverage for: □ Medical □ Dental □ Vision □ Pharmacy □ Behavioral/Mental Health

Insurance Company Name	ID / Policy #	Group #	Effective Date
Policy Holder Name	Policy Holder's Employer (Group Name)		
Employer's Address (PO Box • Number & Street)	City	State	Zip Code / Employer Phone # ( )
Policy Holder's Date of Birth	Policy Holder's Social Security#	Patient's relationship to policyholder?	
Policy Holder's Address (PO Box • Number & Street)	City	State	Zip Code / Phone # ( )

SECTION 6 PATIENT INSURANCE INFORMATION (CONTINUED)

INSURANCE B (SECONDARY)

Includes coverage for: □ Medical □ Dental □ Vision □ Pharmacy □ Behavioral/Mental Health

Private Insurance Company Name	ID / Policy #	Group #	Effective Date
Policy holder's Name	Policy holder's Employer (Group Name)		
Employer's Address (PO Box • Number & Street)	City	State	Zip Code / Employer's Phone # ( )
Policy holder's Date of Birth	Policy holder's Social Security#	Patients Relationship to Insured:	
Policy holder's Address (PO Box • Number & Street)	City	State	Zip Code / Phone # ( )

SECTION 7 PATIENT VETERAN'S INFORMATION

Are you a Veteran? □ Yes □ No	If so, which Branch of service?	Last Entry Date	Separation Date	Claim #

SECTION 8 OTHER PATIENT INFORMATION

Ethnicity:
□ Not Hispanic or Latino
□ Hispanic or Latino
□ Declined to answer
□ Unknown

Race:
□ American Indian
□ Caucasian
□ African American
□ Asian
□ Native Hawaiian

Primary Language:

Preferred Language:

Homeless: □ Y □ N
If yes, Type: □ Homeless Shelter □ Unknown □ Transitional □ Doubling up □ Street □ Other
Migrant Worker: □ Y □ N

Can you access the internet?
□ Yes □ No

If yes, where do you access it?
□ Home □ Work □ Library □ School □ Mobile device □ Tribal center

Email Address:

Preferred method of contact: □ Phone □ Email □ Mail

Act of 1974, P.L. 93-579: I understand that the information given by me and/or collected is necessary for the Indian Health Service staff or I.H.S. contractors (including the Nottawaseppi Huron Band of the Potawatomi) to provide services for my health and well-being. Furthermore, I have been informed that my health record or any portion of the record shall not be disclosed to another agency or person unless necessary for payment of claims, without my signed consent.

I CERTIFY THAT THE INFORMATION GIVEN HERE IS TRUE AND COMPLETED TO THE BEST OF MY KNOWLEDGE. I AGREE REPORT ANY CHANGES IN THIS INFORMATION TO THE CONTRACT HEALTH SERVICES OFFICE IN A TIMELY MANNER.

I authorize the release of any medical or other information necessary to process the claim. I authorize payment of medical benefits to the Physician or supplier of NHBP Health Department for services rendered.

By signing below, I acknowledge that, to the best of my knowledge, all information that I have provided is complete and accurate.

Signature: _____ Date: _____ Staff initial: _____

Patient or Parent / Guardian (please sign in ink)