Sonoma County Indian Health Project, Inc.
144 Stony Point Road
Santa Rosa, California 95401

Patient Registration Form

Department: ☐ Medical ☐ Dental ☐ Behavioral Health	**MRN:**

Full Legal Name (Last, First and Middle) **You must provide Legal documentation for any name changes**

Previous Names	**Date of Birth**

Marital Status			**Sex**	
☐ Single	☐ Divorced	☐ Other:	☐ Male	☐ Female
☐ Married	☐ Widow/Widower			

Social Security Number	**Current Community**

City of Birth	**State of Birth**

Mailing Address (Street or P.O. Box), City, State and Zip Code

Home Address (If different from above), City, State and Zip Code

Home Telephone	**Cell**	**Message Telephone**	**Internet Access**
			☐ Yes ☐ No

Email Address (We cannot share patient information)	**Internet Access Method**
	☐ Home ☐ Work ☐ Phone ☐ Other:

Employer	**Employer Address, City, State and Zip Code**

Employer Telephone	**Household Income (Must enter an amount)**		**Family Size**
	☐ Monthly ☐ Yearly	$	

Primary Language	**Other Language Spoken**	**Preferred Language**

Migrant Worker	**Homeless**	**Religious Preference**
☐ Yes ☐ No	☐ Yes ☐ No	

Race		
☐Asian	☐ Hispanic	☐ Caucasian
☐ African American	☐ Other:_____	
Ethnic Origin		
☐Declined to Answer	☐ Hispanic/Latino	☐Not Hispanic/Latino
☐ Unknown	☐: Other:_____	

Name of Tribe/Tribal Membership	
Assigned Tribal Number	**Total Indian Blood Degree**

Mother's Full Maiden Name	
City of Birth	**State of Birth**
Father's Full Name	
City of Birth	**State of Birth**

Name of Person to Contact in the Event of an Emergency	Relationship
Address, City, State and Zip Code	**Telephone Number**
Next of Kin (Leave blank if person is your Emergency Contact)	**Relationship**
Address, City, State and Zip Code	**Telephone Number**

Veteran's Information		
Veteran: ☐ Yes ☐ No	Service Branch (Last): ☐ Air Force ☐ Army ☐ Marine ☐ Navy ☐ Other:_____	
Service entry date (last): sdfas	Service separation date (last):	
Claim #	Valid VA Card:	Vietnam Service: ☐ Yes ☐ No Service Connected: ☐ Yes ☐ No
Description of VA Disability:		

FINANCIAL POLICY

Sonoma County Indian Health Project, Inc. (SCIHP) is **NOT** a free clinic. We follow regulations and laws set by Indian Health Service and the State of California. Depending on your billing status, you **MAY** be financially responsible for all, part or none of the services performed at SCIHP. Please refer to the Billing Policy and sliding fee scale for each department. By law, SCIHP **must** bill your insurance company for services performed at the clinic.

Insurance Coverage: (Check appropriate box)	☐ Private Insurance ☐ CMS ☐ Medi-Cal ☐ Medicare ☐ Dental ☐ Other:

Insurance Name:	Subscriber Name:	Relationship to Patient:	Insurance Policy #:

AUTHORIZATION TO RELEASE INFORMATION FOR BILLING PURPOSES AND PAYMENT OF BENEFITS TO SONOMA COUNTY INDIAN HEALTH PROJECT, INC.

I hereby authorize the release of any information diagnosis of a medical condition for the sole purpose of submission to Third Party billing insurance carriers and that the statements above are true and correct to the best of my knowledge. I understand that if all insurance information is not complete and correct, I may be financially responsible for services rendered. **I further authorize payment of all service benefits to the Sonoma County Indian Health Project, Inc.**

Insured/Authorized Person Signature	Date

I HEREBY AUTHORIZE AND GIVE CONSENT TO THE HEALTH CARE PROVIDERS AT SONOMA COUNTY INDIAN HEALTH PROJECT, INC. FOR THE FOLLOWING:

1. To take any necessary x-rays, blood samples, urinalysis and other diagnostic test as needed.
2. To administer and prescribe local anesthetics for dental procedures, oxygen, sedatives, analgesics or other medications.
3. To explain the proposed treatment plan, alternative treatment plan, alternative treatments, and any risks and consequences of the treatment.
4. To authorize therapeutic intervention if deemed necessary.

I UNDERSTAND THE FOLLOWING:

1. I can ask further questions if I do not understand the proposed treatment plan, alternative treatments, and any risks and consequences of the treatment.
2. I can refuse treatment and if I refuse treatment, then the consequences will be explained to me.
3. If I do not return for follow-up visits then there may be consequences to my health.
4. The Patient's Rights are posted in the reception area and available upon my request.
5. That the Health Care Providers will provide more specific instructions and consent forms for certain procedures, i.e., extractions, AIDS test, etc.

I HAVE READ THE ABOVE AND ANSWERED ALL THE QUESTIONS, TO THE BEST OF MY KNOWLEDGE.

Signature of patient/responsible party	Date

Print name of patient/responsible party (If Minor)	Print relationship to patient (If Minor)

FOR OFFICIAL USE ONLY

If American Indian, Tribe:	Tribe Code:	Tribal Roll #:	Blood Quantum:	**Direct Care** ☐Yes☐No	**MC on File** ☐Yes☐No	**BC on File** ☐Yes☐No	**CHS** ☐Yes ☐No

Verified Through:	Notes:	Eligibility Officer:	Date: