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

PLEASE PRINT CLEARLY!

PATIENT REGISTRATION FORM

DEPARTMENT	**MEDICAL RECORD NUMBER (MRN)**
☐ MEDICAL ☐ DENTAL ☐ BEHAVIORAL HEALTH ☐ HEALTHY TRADITIONS	

FULL LEGAL NAME (LAST, FIRST, MIDDLE) **YOU MUST PROVIDE LEGAL DOCUMENTS FOR NAME CHANGES**

PREVIOUS NAMES	**NICKNAME(S)**

SOCIAL SECURITY NUMBER	**DATE OF BIRTH**	**SEX AT BIRTH**	**CURRENT GENDER**
		☐ FEMALE ☐ MALE	

MAILING ADDRESS (STREET OR P.O. BOX), CITY, STATE AND ZIP

HOME OF ADDRESS (STREET OR P.O. BOX), CITY, STATE AND ZIP

MARITAL STATUS	**STUDENT STATUS**
☐ SINGLE ☐ MARRIED ☐ DIVORCED	☐ FULL TIME ☐ NOT A STUDENT
☐ WIDOW/WIDOWER ☐ OTHER _____	☐ PART TIME

RACE			
☐ AMERICAN INDIAN	☐ DECLINED TO SPECIFY	☐ WHITE/CAUCASION	☐ OTHER_____
☐ ASIAN	☐ FILIPINO	☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLAND	
☐ BLACK/AFRICAN AMERICAN	☐ HISPANIC/LATINO	☐ UNKNOWN	

PRIMARY CARE PROVIDER	**VETERAN'S INFORMATION**	**SMOKER**
	VETERAN ☐ YES ☐ NO	☐ YES ☐ NO

PREFERRED LANGUAGE	**RELIGION**	**CHURCH**

ETHNICITY		
☐ DECLINE TO ANSWER	☐ HISPANIC/LATINO	☐ NOT HISPANIC/LATINO
☐ UNKNOWN	☐ OTHER_____	

CURRENT COMMUNITY (COUNTY)	**EMAIL ADDRESS** (18 AND OVER ONLY)

TELEPHONE CONTACT PREFERENCE (PLEASE INCLUDE AREA CODE AND ORDER OF CALL PREFERENCE)					
1.	( )	☐ Cell ☐ Home ☐ Work ☐ Message	3.	( )	☐ Cell ☐ Home ☐ Work ☐ Message
2.	( )	☐ Cell ☐ Home ☐ Work ☐ Message	4.	( )	☐ Cell ☐ Home ☐ Work ☐ Message

CALL PREFERENCE (HOW WOULD YOU PREFER YOUR CALLS)	
☐ CONFIDENTIAL	☐ DON'T CALL HOME NUMBER
☐ OKAY TO LEAVE MESSAGE	☐ DON'T CALL WORK NUMBER
☐ DON'T LEAVE MESSAGE	☐ OTHER _____

NOTIFICATION PREFERENCE (AUTOMATED APPOINTMENT REMINDER FOR MEDICAL/HEALTHY TRADITIONS ONLY)			
☐ OPT OUT	☐ EMAIL	☐ TEXT (SMS)	☐ VOICE REMINDER

EMPLOYER NAME		
EMPLOYER ADDRESS, CITY, STATE AND ZIP CODE		**EMPLOYER TELEPHONE**
NAME OF PERSON TO CONTACT IN AN EMERGENCY		**RELATIONSHIP**
ADDRESS, CITY, STATE AND ZIP CODE		
HOME NUMBER	**CELL NUMBER**	**WORK NUMBER**
NEXT OF KIN (LEAVE BLANK IF SAME AS YOUR EMERGENCY CONTACT)		**RELATIONSHIP**
ADDRESS, CITY, STATE AND ZIP CODE		
HOME NUMBER	**CELL NUMBER**	**WORK NUMBER**
MOTHER'S FULL MAIDEN NAME		**DATE OF BIRTH**
FATHER'S FULL NAME		**DATE OF BIRTH**

HOMELESS		
☐ NOT HOMELESS	☐ DOUBLING UP	☐ SHELTER
☐ STREET	☐ TRANSITIONAL	☐ UNKNOWN/UNSPECIFIED

LANGUAGE BARRIER	**MIGRANT WORKER**		
☐ YES ☐ NO	☐ NOT A FARM WORKER	☐ MIGRANT	☐ SEASONAL

NAME OF TRIBE/TRIBAL MEMBERSHIP	
HOUSEHOLD INCOME (MUST ENTER AN AMOUNT)	**FAMILY SIZE** (HOW MANY IN HOUSEHOLD)
☐ MONTHLY ☐ YEARLY ☐ WEEKLY $_____	

WHAT PHARMACY DO YOU USE?		
	Name of Pharmacy	Pharmacy Address
1).		
2).		

FINANCIAL POLICY

Sonoma County Indian Health Project, Inc. (SCIHP) is **NOT** a free clinic. We follow the regulations and laws set by Indian Health Services (IHS) 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. By law, SCIHP **MUST** bill your insurance company for services performed at the clinic.

INSURANCE COVERAGE (CHECK APPROPRIATE BOXES)

☐ PRIVATE INSURANCE ☐ PARTNERSHIP HEALTH PLAN OF CALIFORNIA ☐ MEDI-CAL

☐ MEDICARE ☐ DENTAL INSURANCE ☐ OTHER_____

INSURANCE NAME	SUBSCRIBER NAME
RELATIONSHIP TO PATIENT	**INSURANCE POLICY NUMBER**

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 or diagnosis of a medical condition for the sole purpose of submission to Third Party Billing Insurance carriers and that the statement above is 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: **SONOMA COUNTY INDIAN HEALTH PROJECT, INC.**

INSURED/AUTHORIZED PERSON SIGNATURE	DATE

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

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 treatment 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 plan 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, there may be consequences to my health.
4. The Patient's Rights are posted in the reception area and copies are available upon my request.
5. That the Health Care Providers will provide more specific instructions and consent forms for certain procedures, i.e., extractions, HIV test, etc.

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

SIGNATURE OF PATIENT/RESPONSIBLE PARTY	DATE

PRINT NAME OF PATIENT/RESPONSIBLE PARTY	PRINT RELATIONSHIP TO PATIENT

FOR OFFICIAL USE ONLY

PRC	NAME OF TRIBE	TRIBAL ROLL #	DIRECT CARE	MC ON FILE	BC ON FILE
☐ YES ☐ NO			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

VERIFIED THROUGH	NOTES	ELIGIBILITY OFFICER	DATE

PATIENT NAME:_____ DOB:_____ MRN:_____