Sonoma County Indian Health Project, Inc.
144 Stony Point Road | Santa Rosa, CA 95401 | 707.521.4545

Patient Registration Form

PLEASE PRINT CLEARLY!

Sonoma County Indian Health Project, Inc. (SCIHP) Is required to collect demographic information regarding the patients we serve. The information you provide is confidential.

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**
		☐ Female ☐ Male
Preferred Gender Pronoun	**Gender Identity**	
Mailing Address (Street or P.O. Box), City, State and Zip		
Home Address Street, City, State and Zip		
Mother's Maiden Name	**Preferred Language**	

Marital Status		
☐ Single	☐ Divorced	☐ Other _____
☐ Married	☐ Widow/Widower	

Race		
☐ Asian/Pacific Islander	☐ American Indian/Alaska Native	☐ Unknown/Decline to Specify
☐ Black/African American	☐ Other/More Than One Race	☐ White/Caucasian

Ethnicity	**Email Address** (18 and over only)
☐ Hispanic ☐ Non-Hispanic ☐ Unknown/Decline to Specify	

Telephone Contact Preference (Please Include Area Code)							
1.	☐ Cell	☐ Home	2.	☐ Cell	☐ Home
	☐ Work	☐ Other		☐ Work	☐ Other

Call Preference		**Notification Preference**			
☐ Okay to Leave Message	☐ Don't Leave Message	☐ Opt Out	☐ Email	☐ Text (SMS)	☐ Voice Reminder

PATIENT NAME:_____ DOB:_____ MRN:_____

Parent/Legal Guardian Full Name (Last, First, Middle)	Date of Birth

Parent/Legal Guardian Full Name (Last, First, Middle)	Date of Birth

Additional Contacts

1. Full Legal Name (Last, First, Middle)

Relationship	Date of Birth	Telephone Number	
☑ Care Giver ☐ Emergency Contact ☐ Next of Kin			☐ Cell ☐ Home ☐ Work ☐ Other_____

2. Full Legal Name (Last, First, Middle)

Relationship	Date of Birth	Telephone Number	
☐ Care Giver ☐ Emergency Contact ☐ Next of Kin			☐ Cell ☐ Home ☐ Work ☐ Other_____

Homeless	**Household Income** (Must Enter an Amount)
☐ Not Homeless ☐ Doubling Up ☐ Homeless Shelter ☐ Street/Vehicle ☐ Transitional ☐ Unknown/Unspecified	$_____ ☐ Monthly ☐ Yearly ☐ Weekly

Name of Tribe/Tribal Membership	**Family Size** (How Many in Household)

Head of Household

☐ Self ☐ Other (If other, please complete this section)

Full Legal Name (Last, First, Middle)		
Relationship to Patient	**Date of Birth**	**Sex at Birth**
		☐ Female ☐ Male
Race	**Ethnicity**	**Preferred Language**

What Pharmacies Do You Use?

Name of Pharmacy	*Pharmacy Address*
1.	
2.	

Language Barrier	**Are You a U.S. Military Veteran?**	**Migrant Agricultural Worker**
☐ Yes ☐ No Do you need an interpreter? _____	☐ Yes ☐ No	☐ Not a Farm Worker ☐ Migrant ☐ Seasonal

FOR OFFICIAL USE ONLY

Name of Tribe	Direct Care	MC On File	BC On File	PRC
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Verified Through	Notes	Eligibility Officer	Date

PATIENT NAME:_____ DOB:_____ MRN:_____

Plan 1 – Insurance Company		Subscriber ID
Subscriber Name	**Date of Birth**	**Relationship to Patient**
		☐ Child ☐ Spouse ☐ Parent ☐ Other:_____
Plan 2 – Insurance Company		**Subscriber ID**
Subscriber Name	**Date of Birth**	**Relationship to Patient**
		☐ Child ☐ Spouse ☐ Parent ☐ Other:_____

Last, First, Middle Name (Person financially responsible for all or a portion of patient's healthcare)			
Date of Birth	**Gender**	**Relation to Patient**	**Telephone**
	☐ Female ☐ Male	☐ Self	☐ Cell ☐ Home ☐ Work ☐ Other_____
Primary Address (Street, City, State and Zip)			

FINANCIAL POLICY/PAYMENT FOR SERVICES RENDERED

SCIHP is not a free clinic. I, the undersigned certify the information given to SCIHP for payment by third parties is correct. I authorize payment of benefits for services furnished by **Sonoma County Indian Health Project, Inc.** and authorize SCIHP to release minimum necessary patient health information related to the visit for Health Care Financing Administration, California Department of Health Services or other agents which is necessary to determine benefits or payment for services under these programs.

I understand if all insurance information is **NOT** complete and correct, I **MAY** be financially responsible for services rendered by law. I further understand SCIHP **MUST** bill the insurance company for services performed at SCIHP.

AUTHORIZATION AND CONSENT

I Hereby Authorize and Give Consent to Health Care Providers at Sonoma County Indian Health Project, Inc. (SCIHP):

1. To order and process X-Rays, blood samples, urinalysis, and diagnostic test as needed.
2. To administer and prescribe local anesthetics, oxygen, sedatives, immunizations, analgesics or other medications.
3. To explain the proposed treatment plan, alternative treatment plan, and any potential risks and consequences of the treatment.
4. To authorize and provide 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 or risks and consequences associated with the treatment plan.
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. That the Patient Rights and Responsibilities are posted in the reception area and copies are available upon my request.
5. Health care providers will provide more specific instructions and consent forms for certain procedures, i.e., extractions, HIV test, etc.
6. Physician Assistants (PA) and Nurse Practitioners (FNP) practicing at SCIHP are supervised by a licensed Physician.

Signature of Patient/Responsible Party	Date

Print Name of Patient/Responsible Party	Print Relationship to Patient