



## 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.*

<b>Full Legal Name (Last, First, Middle) You Must Provide Legal Documents for Name Changes</b>			
<b>Previous Names</b>	<b>Nickname(s)</b>	<b>Mother's Maiden Name</b>	<b>Preferred Language</b>
<b>Social Security Number</b>		<b>Date of Birth</b>	<b>Sex at Birth</b>
			<input type="checkbox"/> Female <input type="checkbox"/> Male
<b>Gender Identity</b>			
<input type="checkbox"/> Choose not to disclose		<input type="checkbox"/> Genderqueer, neither exclusively male nor female	
<input type="checkbox"/> Additional gender category or other, please specify		<input type="checkbox"/> Male	
<input type="checkbox"/> Female		<input type="checkbox"/> Male-to-Female (MTF)/Transgender Female/Trans Woman	
<input type="checkbox"/> Female-to-Make (FTM)/Transgender Male/Trans Man			
<b>Preferred Gender Pronoun</b>			
<input type="checkbox"/> None	<input type="checkbox"/> Asked but unknown	<input type="checkbox"/> He, Him, His	<input type="checkbox"/> She, Her, Hers
<input type="checkbox"/> Decline to answer	<input type="checkbox"/> They, Them, Theirs	<input type="checkbox"/> Ze, Hir	
<b>Sexual Orientation</b>			
<input type="checkbox"/> Straight or heterosexual	<input type="checkbox"/> Choose not to disclose	<input type="checkbox"/> Bisexual	
<input type="checkbox"/> Lesbian, gay, homosexual	<input type="checkbox"/> Don't know	<input type="checkbox"/> Something else, please describe	
<b>Mailing Address (Street or P.O. Box), City, State and Zip</b>		<b>Home Address Street, City, State and Zip</b>	
<b>Marital Status</b>			
<input type="checkbox"/> Single		<input type="checkbox"/> Divorced	<input type="checkbox"/> Other _____
<input type="checkbox"/> Married		<input type="checkbox"/> Widow/Widower	
<b>Race</b>			
<input type="checkbox"/> Asian/Pacific Islander		<input type="checkbox"/> Native American/Eskimo/Aleut	<input type="checkbox"/> Unknown/Decline to Specify
<input type="checkbox"/> Black/African American		<input type="checkbox"/> Other/More Than One Race	<input type="checkbox"/> White/Caucasian
<b>Ethnicity</b>		<b>Email Address (18 and over only)</b>	
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown/Decline to Specify			
<b>Telephone Contact Preference (Please Include Area Code)</b>			
1. (   )		<input type="checkbox"/> Cell <input type="checkbox"/> Home	2. (   )
		<input type="checkbox"/> Work <input type="checkbox"/> Other	<input type="checkbox"/> Cell <input type="checkbox"/> Home
			<input type="checkbox"/> Work <input type="checkbox"/> Other
<b>Call Preference</b>		<b>Notification Preference</b>	
<input type="checkbox"/> Okay to Leave Message <input type="checkbox"/> Don't Leave Message		<input type="checkbox"/> Opt Out <input type="checkbox"/> Email <input type="checkbox"/> Text (SMS) <input type="checkbox"/> Voice Reminder	

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ MRN: \_\_\_\_\_

<b>Parent/Legal Guardian Full Name (Last, First, Middle)</b>			<b>Date of Birth</b>	
<b>Additional Contacts</b>				
<b>1. Full Legal Name (Last, First, Middle)</b>				
<b>Relationship</b>		<b>Date of Birth</b>	<b>Telephone Number</b>	
<input type="checkbox"/> Care Giver <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Next of Kin			(    )	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____
<b>2. Full Legal Name (Last, First, Middle)</b>				
<b>Relationship</b>		<b>Date of Birth</b>	<b>Telephone Number</b>	
<input type="checkbox"/> Care Giver <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Next of Kin			(    )	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____
<b>Homeless</b>			<b>Household Income (Must Enter an Amount)</b>	
<input type="checkbox"/> Not Homeless <input type="checkbox"/> Doubling Up <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Street/Vehicle <input type="checkbox"/> Transitional <input type="checkbox"/> Unknown/Unspecified			\$_____ <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly	
<b>Name of Tribe/Tribal Membership</b>			<b>Family Size (How Many in Household)</b>	
<b>Head of Household</b>				
<input type="checkbox"/> Self <input type="checkbox"/> Other (If other, please complete this section)				
<b>Full Legal Name (Last, First, Middle)</b>				
<b>Relationship to Patient</b>		<b>Date of Birth</b>		<b>Sex at Birth</b>
				<input type="checkbox"/> Female <input type="checkbox"/> Male
<b>Race</b>		<b>Ethnicity</b>		<b>Preferred Language</b>
<b>What Pharmacies Do You Use?</b>				
<i>Name of Pharmacy</i>			<i>Pharmacy Address</i>	
1.				
2.				
<b>Language Barrier</b>		<b>Are You a U.S. Military Veteran?</b>		<b>Migrant Agricultural Worker</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you need an interpreter? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Not a Farm Worker <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal
<b>FOR OFFICIAL USE ONLY</b>				
<b>Name of Tribe</b>			<b>Direct Care</b>	<b>MC On File</b>
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<b>BC On File</b>	<b>PRC</b>
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Verified Through</b>		<b>Notes</b>		<b>Eligibility Officer</b>
				<b>Date</b>

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ MRN: \_\_\_\_\_

<b>Plan 1 – Insurance Company</b>		<b>Subscriber ID</b>	
<b>Subscriber Name</b>	<b>Date of Birth</b>	<b>Relationship to Patient</b>	
		<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____	
<b>Plan 2 – Insurance Company</b>		<b>Subscriber ID</b>	
<b>Subscriber Name</b>	<b>Date of Birth</b>	<b>Relationship to Patient</b>	
		<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____	
<b>Last, First, Middle Name (Person financially responsible for all or a portion of patient's healthcare)</b>			
<b>Date of Birth</b>	<b>Gender</b>	<b>Relation to Patient</b>	<b>Telephone</b>
	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Self	(   ) <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____
<b>Primary Address (Street, City, State and Zip)</b>			
<b>FINANCIAL POLICY/PAYMENT FOR SERVICES RENDERED</b>			
<p>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 <b>Sonoma County Indian Health Project, Inc.</b> 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.</p> <p>I understand if all insurance information is <b>NOT</b> complete and correct, I <b>MAY</b> be financially responsible for services rendered by law. I further understand SCIHP <b>MUST</b> bill the insurance company for services performed at SCIHP.</p>			
<b>AUTHORIZATION AND CONSENT</b>			
<b>I Hereby Authorize and Give Consent to Health Care Providers at Sonoma County Indian Health Project, Inc. (SCIHP):</b>			
<ol style="list-style-type: none"> <li>To order and process X-Rays, blood samples, urinalysis, and diagnostic test as needed.</li> <li>To administer and prescribe local anesthetics, oxygen, sedatives, immunizations, analgesics or other medications.</li> <li>To explain the proposed treatment plan, alternative treatment plan, and any potential risks and consequences of the treatment.</li> <li>To authorize and provide therapeutic intervention if deemed necessary.</li> </ol>			
<b>I Understand the Following:</b>			
<ol style="list-style-type: none"> <li>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.</li> <li>I can refuse treatment and if I refuse treatment, then the consequences will be explained to me.</li> <li>If I do not return for follow-up visits, there may be consequences to my Health.</li> <li>That the Patient Rights and Responsibilities are posted in the reception area and copies are available upon my request.</li> <li>Health care providers will provide more specific instructions and consent forms for certain procedures, i.e., extractions, HIV test, etc.</li> <li>Physician Assistants (PA) and Nurse Practitioners (FNP) practicing at SCIHP are supervised by a licensed Physician.</li> </ol>			
<b>Signature of Patient/Responsible Party</b>			<b>Date</b>
<b>Print Name of Patient/Responsible Party</b>		<b>Print Relationship to Patient</b>	

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ MRN: \_\_\_\_\_