NOTTAWASEPPI HURON BAND OF THE POTAWATOMI

A FEDERALLY RECOGNIZED TRIBAL GOVERNMENT

**MNO BMADZEWEN • HEALTH AND HUMAN SERVICES**

# PATIENT REGISTRATION

HRN #: _____ Date Received: _____

| **SECTION 1** | **PATIENT DEMOGRAPHIC** | | | | |
|---|---|---|---|---|---|
| Patient's Name: (Last) (First) (Middle) | | | Date of Birth (m/d/yy) | Place of Birth (city & state) | |
| Physical Address: | | | Sex | Social Security # | Marital Status |
| Mailing Address: (If Different or P.O. Box) | | | City | County | State / Zip |
| Home Phone #: | Work Phone #: | Cell/Other Phone #: | Present Community: (City Living In) | | |
| Is patient enrolled with Nottawaseppi Huron Band of the Potawatomi (NHBP)? ☐ Yes ☐ No<br>Is patient a direct descendant of a Nottawaseppi Huron Band of the Potawatomi member? ☐ Yes ☐ No<br>Is patient enrolled or a direct descendant of other Federally Recognized Tribe? ☐ Yes ☐ No<br>If other than NHBP please specify which Tribe: | | | Enrollment #: | Tribal Blood Quantum:<br>Total Blood Quantum: | |

| **SECTION 2** | **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 your care, please list the individual(s) below. | | | |
| Name of Emergency Contact: | Phone #: | Relationship: (Is the 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 3** | **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)<br>Father's Contact Phone #: | |
| Mother's Maiden Name: (Last, First) | | Mother's Place of Birth: (City & State)<br>Mother's Contact Phone #: | |

| **SECTION 4** | **PATIENT EMPLOYER INFORMATION** | | |
|---|---|---|---|
| Patient's Employer Name: (if applicable) | Address: (City, State, Zip) | ☐ Full Time ☐ Part Time | Work Phone #: |

| **SECTION 5** | **PATIENT VETERAN'S INFORMATION** | | | |
|---|---|---|---|---|
| Are You a Veteran? ☐ Yes ☐ No | If so, which Branch of Service? | Last Entry Date: | Separation Date: | Claim#: |

## SECTION 6 PATIENT INSURANCE INFORMATION

**NO INSURANCE** ☐ I do not have any insurance (go to Section 8)

| | | | |
|---|---|---|---|
| **MEDICARE**: (if applicable)<br>Do you have Part A? _____ Part B? _____ Part D? _____ | | | Medicare Number: |
| **MEDICAID**: (if applicable)<br>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 Name: (Group Name) | |
| Policy Holder's Date of Birth: | Policy Holder's Social Security#: | Patient's Relationship to Insured? | |

| | | | | |
|---|---|---|---|---|
| Policy Holder's Address (PO Box • Number & Street) | City: | State: | Zip Code: | Phone #: |

## SECTION 7 PATIENT INSURANCE INFORMATION (CONTINUED)

**PRIVATE INSURANCE B (SECONDARY)**

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

| | | | |
|---|---|---|---|
| Insurance Company Name: | ID/Policy #: | Group#: | Effective Date: |
| Policy Holder Name: | | Policy Holder's Name: (Group Name) | |

| | | | | |
|---|---|---|---|---|
| Employer's Address (PO Box Number & Street) | City: | State: | Zip Code: | Phone #: |

| | | |
|---|---|---|
| Policy Holder's Date of Birth: | Policy Holder's Social Security#: | Patient's Relationship to Insured? |

| | | | | |
|---|---|---|---|---|
| Policy Holder's Address (PO Box Number & Street) | City: | State: | Zip Code: | Phone #: |

## SECTION 8 OTHER PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Ethnicity:<br>☐ Not Hispanic or Latino<br>☐ Hispanic or Latino<br>☐ Declined to answer<br>☐ Unknown | Race:<br>☐ American Indian<br>☐ Caucasian<br>☐ African American<br>☐ Asian<br>☐ Native Hawaiian | Primary Language:<br><br><br>Preferred Language: | Homeless: ☐ Yes ☐ No<br>If yes, Type: ☐ Homeless Shelter ☐ Unknown<br>☐ Transitional ☐ Doubling Up<br>☐ Street ☐ Other<br>Migrant Worker: ☐ Yes ■ No |

| | |
|---|---|
| Can you access the Internet?<br>☐ Yes ☐ No | If yes, where do you access it?<br>☐ 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. Futhermore, 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 TO 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)