New Patient Registration Form

River People
Health Center

PATIENT DEMOGRAPHICS

Patient's first name:	Suffix: (Jr, Sr, III)	☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Significant Other

Maiden name or others used:	Date of birth:	Social security#	Place of birth (City & State):	Sex: ☐ M ☐ F ☐ Unk

Mailing address:	City	State	Zip
Physical location of home:	City	State	Zip

Community name and how long in community?	Which reservation?	Home # ( ) Cell # ( )
Religion preference:		Email Address:

PATIENT'S EMPLOYMENT INFORMATION

Are you employed? ☐ Yes ☐ No	If No, how long?	Spouse/significant other employed? ☐ Yes ☐ No	If No, how long?
Patient's Employer:		Spouse's Employer:	
☐ Fulltime ☐ Part time ☐ Retired ☐ Temporary		☐ Full time ☐ Part time ☐ Retired ☐ Temporary	
How long with employer?		How long have they been with this employer?	
Patient's Employer Phone:		Spouse's Employer Phone:	
Are you a student? ☐ Yes ☐ No ☐ FT ☐ PT		Spouse or significant other a student? ☐ Yes ☐ No ☐ FT ☐ PT	

PARENT INFORMATION

*** Information needed for minor patients ***

Mother's full name (Maiden):	Mother's birthplace (City/Sate):	Mother's DOB:	Mother's SSN:
Father's full name:	Father's birthplace (City/State):	Father's DOB:	Father's SSN:
Mother's employer:	Mother's employer phone:	Father's employer:	Father's employer phone:

TRIBAL DATA

*** Please provide proof of tribal enrollment ***

Are you enrolled in a federal recognized tribe?	☐ Yes ☐ No	☐ Full 414 ☐ Half 1/2 ☐ Qtr 3/4 ☐ Qtr 1/4 ☐ Other: _________
Tribe of membership:		Tribal enrollment (Census) #:

INSURANCE INFORMATION

*** Please present your insurance card ***

☐ Medicaid (AHCCCS)	Medicaid ID #:	Health Plan:
☐ Medicare	Medicare ID#:	☐ Part A ☐ Part B ☐ Part D

☐ Private Insurance (ex: Aenta/BCBS/Ameriben)	Insurance name & address:	
	Who is the policyholder?	Member ID#:
	Policyholder's SSN:	Policyholder's DOB: