New Patient Registration Form

River People
Health Center

PATIENT DEMOGRAPHICS

Patient's Full Name: (First Mid Last):	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:

River People Health Center

EMERGENCY CONTACT & NEXT OF KIN

Emergency contact name:	**Next of kin name:**
Relationship to patient:	Relationship to patient:
Address:	Address:
City/State:	City/State:
Phone#:	Phone#:

OTHER PATIENT DATA

Veteran: ☐ Yes ☐ No	Service branch:	Service entry date:	Service separation date:

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown ☐ Decline to Answer

Race: ☐ American Indian/Alaskan Native ☐ African American ☐ Asian ☐ White ☐ Decline to Answer

Primary language:	Other language:	Preferred language:
Interpreter Required: ☐ Yes ☐ No	Migrant Worker: ☐ Yes ☐ No	Homeless: ☐ Yes ☐ No

Internet access? ☐ Yes ☐ No (Home / Work / School / Mobile / Library)

AUTHORIZATION SIGNATURES

I understand that after verifying eligibility and applying for a new health record, an electronic health record may be created with Salt River Pima-Maricopa Indian Community-River People Health Center. I understand the information provided will be stored in my health record which is necessary to provide service(s) for my health. I certify the above information is true to the best of my knowledge.

____ ____________________

Patient/Parent or Guardian Signature / Print *Date*

____ ____________________

Employee Signature / Print *Date*

FOR OFFICIAL USE ONLY

Health Record Number:	HIM Technician:
Eligibility: ☐ Direct ☐ Ineligible ☐ Pending	Eligibility Documents: ☐ CIB ☐ Descendant ☐ B/C ☐ SSC ☐ DL/ID

Reason for Pending: ☐ No Eligibility Documents ☐ No Proof of Descendancy

If documents are not submitted within 30 days, eligibility will revert to INELIGIBLE and may incur charged billings

☐ Data Entry into RPMS/BPRM	
☐ NPP entry in RPMS/BPRM (Page 9)	
☐ AOB entry in RPMS/BPRM (Page 9)	
☐ Verified Insurance Information	
☐ No A/R--Referred to Contact Rep:______________________	
☐ Scanned New Chart Form, AOB, and NPP Form into Vista	