# New Patient Registration Form

River People Health Center

## PATIENT DEMOGRAPHICS

| | | | |
|---|---|---|---|
| Patient's full name: (First Middle Last Suffix (Jr, Sr, III): | | Social security number: | Date of birth: |
| Other names used: | Legal sex:<br>❑ Male ❑ Female<br>❑ Unkn ❑ Nonbinary | Gender identity: ❑ M ❑ F ❑ Transgender M/F<br>❑ Two Spirit ❑ Questioning ❑ Choose not to disclose<br>❑ Other: _____ | |
| Mailing address: | City | State | Zip |
| Physical address if mailing address is PO Box: | City, State, Zip | How long address: | Community: |
| Phone numbers:<br>Primary # ( ) ❑ Mobile ❑ Home ❑ Work<br>Secondary # ( ) ❑ Mobile ❑ Home ❑ Work | | Appointment Reminders<br>❑ Text Msg ❑ Automated Phone ❑ Live Manual | |
| Email address: | Would you like to access MyChart? ❑ Text ❑ Email ❑ Decline signup | | |
| Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widow ❑ Separated ❑ Significant Other ❑ Unknown | Religion preference: | | |
| Ethnicity: ❑ Not Hispanic/Latino ❑ Hispanic/Latino ❑ Cuban ❑ Mexican/American/Chicano ❑ Puerto Rican ❑ Choose not to Answer ❑ Unkn | | | |
| Race: ❑ American Indian/Alaskan Native ❑ African American ❑Asian ❑Native Hawaiian ❑ White ❑ Decline to Answer ❑Other: | | | |

## PARENT/LEGAL GUARDIAN INFORMATION

*** Information needed for minor patients ***

Who is completing application? ❑ Biological Parent(s) ❑ Legal Guardian: ❑ Relative _____ ❑ Foster Parent(s) ❑ Court Appointed

| | | | | |
|---|---|---|---|---|
| Mother's full name (Maiden): | Mother's DOB: | Mother's SSN: | Same household:<br>❑ Yes ❑ No | Emerg contact:<br>❑ Yes ❑ No |
| Father's full name: | Father's DOB: | Father's SSN: | Same household:<br>❑ Yes ❑ No | Emerg contact:<br>❑ Yes ❑ No |
| Mother's employer: | Mother's cell/contact phone: | | Father's employer: | Father's cell/contact phone: |
| Legal guardian full name: | Legal guardian phone: | Same household:<br>❑Yes ❑ No | Legal guardianship documents?<br>❑Yes ❑ No ❑ Temporary guardian | Proxy Consent?<br>❑ Yes ❑ No ❑ |

## PATIENT CONTACTS

| | |
|---|---|
| 1. Emergency contact name: | 2. Emergency contact name or Health Care Agent/Power of Attorney: |
| Relationship to patient: | Relationship to patient: |
| Address: | Address: |
| City/State: | City/State: |
| Phone#: | Phone#: |

## ADDITIONAL PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Employed? ❑ Yes ❑ No | ❑ FT ❑ PT ❑ Retired ❑ Student | Spouse/significant other employed?<br>❑ Yes ❑ No | ❑ FT ❑ PT ❑ Retired ❑ Student |
| Patient's employer: | | Spouse's employer: | |
| Employer address: | | Employer address: | |
| Patient's employer phone: | | Spouse's employer phone: | |

## TRIBAL ELIGIBILITY INFORMATION

| | | | |
|---|---|---|---|
| Tribe of membership: | Blood quantum: ❑ Full 4/4 ❑ Half 1/2 ❑ Qtr 3/4 ❑ Qtr 1/4 ❑ Other: | | |
| Tribal enrollment #: | Interpreter required: ❑ Yes ❑ No | Preferred language: | |
| English fluency: ❑ Excellent ❑ Good ❑ Not at all ❑ Not good ❑ Very good | | Other language: | |
| Veteran/Military status: ❑ Active Duty ❑ Inactive Duty ❑ Reservist ❑ Veteran ❑ None | | Military start date: | Military end date: |

## PATIENT ASSISTANCE

Patient assistance: ❑ Low vision ❑ Hard of hearing ❑ Memory impaired ❑Physically impaired ❑ None ❑ Other:

Accessibility needs: ❑ Wheelchair ❑ Walker ❑ Crutches ❑ Cane ❑ None ❑ Other:

## INSURANCE COVERAGE

*** Please present your insurance card ***

| | | | |
|---|---|---|---|
| ❑ Medicaid (AHCCCS) | Medicaid ID #: | Health Plan: | |
| ❑ Medicare | Medicare ID#: | ❑ Part A ❑ Part B ❑ Part D | |
| ❑ Private Insurance (ex: Aetna/BCBS/) | Insurance name & address: | | |
| | Who is the policyholder? | | Member ID#: |
| | Policyholder's SSN: | Policyholder's DOB: | |
| ❑ Dental / ❑ Vision | Insurance name: | Who is the policyholder? | |
| ❑ No insurance | ❑ I would like to meet with a benefit coordinator today ❑ Have a benefit coordinator call me | | |

## 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 Department of HHS. 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

| | |
|---|---|
| Medical Record Number: | Employee Name: |
| Eligibility: ❑CHS & Direct ❑Direct ❑Ineligible ❑Pending Verf | Eligibility Documents: ❑ CIB ❑ Descendant ❑ B/C ❑ SSC ❑ DL/ID |
| Reason for Pending: ❑ No Proof of Eligibility (CIB/Tribal ID Card) Documents ❑ No Proof of Descendant<br>❑ Patient flag entered in EPIC—Registration Patient Alert *"Patient to submit CIB for ELIG 1st Visit/Initial & date"* | |
| ❑ Complete data entry into EPIC | |
| ❑ E-SIG RPHC General Consent ❑ E-SIG Dental General Consent ❑ E-SIG BHS General Consent<br>❑ 1 year expiration date entered in EPIC | |
| ❑ E-SIG Customer Rights & Responsibility<br>❑ 1 year expiration date entered in EPIC | |
| ❑ E-SIG HIPAA | |
| ❑ E-SIG General Patient ROI<br>❑ N/A | |
| Patient contacts: ❑ Biological parents entered ❑ N/A ❑ Legal guardian entered ❑ N/A ❑ Proxy entered ❑ N/A | |
| ❑ Communication preference set<br>❑ MyChart Activation link sent | |
| ❑ Guarantor set and insurance entered in EPIC (Patient and encounter level)<br>❑ Verified insurance information<br>❑ No insurance, referral entry to BCs | |