New Patient Registration
Special Circumstances Registration

CONFIDENTIAL INFORMATION

Welcome to the Nisqually Health Center! Please fill out this form completely. If you have any questions or concerns, please do not hesitate to ask for assistance, we will be happy to help!

PATIENT INFORMATION:

SSN:____

Patient Name (First, MI, Last): ____

Sex: ☐ Male ☐ Female

Tribe:_______________________, or Non -Tribal_____________

Date of Birth: __________________

Marital Status (circle one): ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Mailing Address: ___________________________ City: _____________ State: ____ Zip: _______

Street Address (if different): ____

Email Address: ____

Phone #: ______________Cell #: ______________ Work #: ________________ Ext. ____

Place of Employment (check one):
Nisqually Tribe___, Nisqually Red Wind Casino__ Nisqually Markets__

Eligibility Category: Nisqually Community household___, Care Giver for Tribal Elder___,
Nisqually Tribe Employee household___ - Name of Employee__________________

PRIMARY INSURANCE INFORMATION:

Insurance Company Name: ____

Address: ____

Policy#_______________________________ Group#:_______________

What does the plan cover? (Circle all that apply): Medical/Dental/Vision/Rx/Mental Health

Policy Holder's Name: __________________________

Policy Holder Phone #: ___________________

Relationship to Patient: _____________________

Policy Holder's DOB: __________

Whom can we contact in case of an emergency?

Name: ____

Relationship: _________________Address: ______________________

Phone: ______________________

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

POLICY HOLDER'S NAME: ____

*D.O.B:*___________________________ *SS#*______________________________________

*CURRENT ADDRESS:*____

The Nisqually Tribal Health Department may disclose all or any part of the patient's record to any person or third party supplementary plan, which is or may be liable under a contract with the Clinic, the Patient, a family member and /or employer of the patient for all or part of the Clinics charge. Including, but not limited to Insurance companies, workman's comp./other etc., ***Medicare*** *and Medicaid.*

I hear by assign, transfer and set over to Nisqually Tribal Health Department all my right, title and interest to my medical reimbursement benefits under my Medicare or Insurance coverage, as well as any other third party liability reimbursements.

*******I authorize the release of any information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. *******

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. IF ANY OF THIS INFORMATION CHANGES, I WILL BRING IN THE CORRECT INFORMATION.

____ ____________________________

Signature of Patient ***Date***