SOUTHERN INDIAN HEALTH COUNCIL, INC.
4058 Willows Road Alpine, CA 91901
Mailing: P.O. Box 2128 Alpine, CA 91903
Phone: (619) 445-1188

PATIENT REGISTRATION

Office Use Only: Chart: ____________ Register Date: __/__/__

Eligibility D C I P Eligibility Determination Made By: ____________

Patient's Legal Name: ____________ Last ____________ First ____________ Middle Initial (Maiden)

Other Names Known By: ____________

Home Address: ____________ Street ____________ City ____________ State ____________ Zip

Mailing Address: ____________ Street ____________ City ____________ State ____________ Zip

Preferred Phone #: (___) ___-____ Other Phone #: (___) ___-____ Work Phone #: (___) ___-____

Internet Access: ☐Yes ☐No Email Address: ________@______.____ Social Security #: ___-__-____

Date of Birth: __/__/__ Birthplace: ____________ City ____________ State ☐Male ☐Female

☐Child/Infant ☐Single ☐Married Spouse's Name: ____________

Race: ☐American Indian
☐Asian
☐African American
☐Hispanic
☐Caucasian
☐Pacific Islander
☐Other Non-Caucasian

If American Indian:
Tribe: ____________
Tribal Roll #: ____________
Tribal Blood Quantum: ____________
Indian Blood Quantum: ____________
If you are not American Indian, are you a member of an Indian Household? ☐Yes ☐No

Primary Language: ____________ Preferred Language: ____________

Occupation: ____________ Name of Employer: ____________

U.S. Veteran: ☐Yes ☐No Service Branch: ____________

Vietnam Vet: ☐Yes ☐No Separation Date: __/__/__

Father's Full Name: ____________ ____________ Father's Birthplace ____________ Father's Tribe

Mother's Maiden Name: ____________ ____________ Mother's Birthplace ____________ Mother's Tribe

Person to Contact in Case of Emergency: ____________ Name ____________ Relationship

____________ Street ____________ City ____________ State ____________ Zip ____________ Phone#

Person Responsible for Payment: ____________ Name ____________ Relationship

Income Information: # of Persons in the Household ___ Annual Household Income $__________

Certification Statement: I certify that the information above is true and accurate to the best of my knowledge. I hereby assign all benefits to include major healthcare benefits to which I am entitled, including MediCal, Medicare, private insurance and any other health insurance plan to Southern Indian Health Council, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

____
NAME OF PATIENT (PRINT)

____
NAME OF RESPONSIBLE PARTY (PRINT)

__/__/__
DATE

____
SIGNATURE OF RESPONSIBLE PARTY/LEGAL GUARDIAN

____
DRIVER'S LICENSE NUMBER

How did you hear about SIHC? Physician, Insurance Referral, or Other, please indicate: