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: _____ ☐Male ☐Female
City State

☐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:

_____

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GENERAL CONSENT FOR DIAGNOSIS AND TREATMENT

NAME OF PATIENT: _____ ___/___/___
DATE OF BIRTH

The undersigned patient/legal guardian consents for the above named patient to receive the rendering of such care including diagnostic procedures and medical treatment by the physicians, nurse practitioner (who are under the general supervision of our physicians) and other members of the medical staff of Southern Indian Health Council as may in their professional judgment be deemed necessary or beneficial, including routine immunization administered according to accepted schedules. This consent includes the right to use minimal necessary protected health information for the purpose of treatment, payment or operations.

For minor or dependent patients only:
If minor or other dependent patient will be accompanied to the clinic by adult person other than the parent(s) or legal guardian, please list their name(s) and relationship below:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

By signing below, the patient/guardian acknowledges the above statements have been read. This consent shall remain in effect as long as the patient utilizes the services of Southern Indian Health Council unless revoked in writing.

NOTICE OF PRIVACY PRACTICES/ ADVANCE HEALTH CARE DIRECTIVE

I acknowledge I have been offered a copy of Southern Indian Health Council's Notice of Privacy Practices and Advance Health Care Directive.

By signing below I acknowledge receipt refusal of the documents.
(Circle one)

Print Name: _____ Date: _____

Signature: _____ Patient Guardian
(Circle one)

Relationship to Patient: _____ Witness: _____

Date revised: June 2009

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Dear Patient:

*Be advised that all patients coming to Southern Indian Health Council must provide proof of insurance, Medi-cal or Medicare. Native Americans must provide verification, tribal affiliation or a letter from the Bureau of Indian Affairs. If verification is not provided, only the initial office visit will be covered free of charge. If you are not covered by Contract Care Services, you may be charged for laboratory services, medication and x-ray fees.

ALL FEES MUST BE PAID AT TIME OF SERVICES.

*Any services not covered by your insurance will be your responsibility to pay. We appreciate your cooperation. If you have any questions feel free to ask

*I have read and understand this letter regarding payment for all services and Native American verification.

Patient Name_____ Date_____

Signed_____ Relation:_____
(Patient/Guardian)

Date revised: June 2009

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ADULT HEALTH AND MEDICAL QUESTIONNAIRE

Name_____ Sex M F DOB _____

Allergies: _____

Illness/Medical Problem Year

_____

_____

_____

_____

_____

_____

Surgeries or Other Hospitalizations (include dates):

_____

_____

_____

_____

Current Medications: Include all prescriptions and over the counter drugs: eye drops, birth control, diet pills, hormones, aspirin, also list any vitamins and herbal or natural supplements, include name dose frequency.

_____

_____

_____

_____

_____

_____

Marital Status_____ Children? _____

Sexually Active/Contraception _____

Last Cholesterol Test _____ Last Tetanus Injection _____

Last Pap Smear _____ Last Mammogram _____
Last TB Test _____

Occupation _____

Tobacco Use/ Exposure _____ Drug Use _____

Alcohol_____ Caffeine (Coffee, tea, cola, etc) _____

Past Medical History: Please circle below any problems you have presently or have had in the past. Please fill in anything else that you feel might be significant:

GENERAL: Unwanted weight change, loss of appetite, heat/cold intolerance, problems sleeping, fatigue, etc.

NEUROLOGICAL: Headaches/migraines, seizures, memory loss, loss of consciousness, mood changes, weakness, dizziness, depression/anxiety, etc.

EAR/NOSE/THROAT: Chronic runny nose/sore throat, hoarseness, sinus, hearing problems, earaches, nosebleeds, etc.

EYES: Glaucoma, cataracts, visual disturbances, etc.

HEART/CIRCULATION: Chest pain, swollen ankles, shortness of breath, fluttering in chest, heart murmur, etc.

LUNGS/CHEST: Wheezing, cough, difficulty breathing, coughing up blood, etc.

DIGESTIVE TRACT: Difficulty swallowing, black or bloody stool, diarrhea/constipation, gas/bloating, nausea/vomiting, heartburn, stomach pains, yellow jaundice, etc.

Genital/Urinary: Blood in urine, urgency/frequency, decreased flow, kidney stones loss of control, burning, discharge, erectile problems, etc.

MUSCLES/BONES: Back/neck pain, arthritis, gout, numbness/tingling, leg pains, etc.

SKIN: Mole changes, non healing sores, rashes, eczema, etc.

GYNECOLOGICAL: PMS, heavy periods, menopause, discharge, painful intercourse, breast lumps, etc.

GLANDS/HORMONES: Excessive thirst, tremors/shakes, hair loss, dry skin, frequent urination, thyroid problems, etc.

BLOOD/LYMPH NODES: Lymph node swelling, easy bruising, tendency to bleed anemia, etc.

FAMILY HISTORY: Please specify relationship of family member (must be blood relative)

Asthma/Allergy	Diabetes
Cancer (type)	Arthritis
High Blood Pressure	Heart Attack
Heart Disease	Alzheimer's/Dementia
Epilepsy/Seizures	Migraine
High Cholesterol	Alcohol/ Substance Abuse
Lung Disease	Tuberculosis
Birth Defects/Retardation	Mental Illness/Depression
Liver/Hepatitis	Stomach/Bowel Problems
Bleeding Disorder	Anemia
Stroke	Glaucoma
Thyroid	Osteoporosis
Sickle Cell Trait	Frequent Infections

Do any illnesses run in the family? (Specify)_____

_____

_____

Southern Indian Health Council

BIRTH HISTORY

Date of birth: _____

Place of birth: _____

Birth weight: _____lbs. _____oz.

Birth Length _____ inches

How many months pregnant when born? _____months

Any problems during pregnancy? _____

_____

_____

Type of delivery: Vaginal _____ Cesarean_____

Any Complication during or after delivery? _____

_____

_____

How long did you and the baby stay in the hospital after delivery? _____days

FAMILY HISTORY

Mother's Name _____

Father's Name _____

Number of Brothers _____ Sisters _____

Any Health Problems? _____

_____

_____

Any Family History of:

	YES/NO	*WHO?*
Diabetes	_____	_____
High blood Pressure	_____	_____
Allergies	_____	_____
Seizures	_____	_____
Tuberculosis	_____	_____
Cancer	_____	_____
Heart Disease	_____	_____
Asthma	_____	_____

DEVELOPMENT

Age of rolling over _____ Age of sitting _____

Age of walking _____ Toilet Trained? _____

Age of first tooth _____

ILLNESSES

Major Illnesses _____

_____

_____

Hospitalizations _____

_____

_____

Surgeries _____

_____

_____

MEDICATIONS

Any medication taken? _____

_____

Allergies to medications? _____

_____

IMMUNIZATIONS

PLEASE PROVIDE THE CLINIC WITH A COPY OF ANY IMMUNIZATIONS YOUR CHILD HAS RECEIVED.

MISCELLANEOUS

Does any one at home smokes? _____

Any sleeping problems? _____

Any feeding problems? _____

School grade_____ Any problems at school? _____

_____

_____

Name _____ **Chart #**_____ **Date**_____