Data Entry _____ Vrfd _____
HRN _____

Cowlitz Indian Tribe

Health Services Patient Registration

☐ *New Pt Reg* ☐ *Update*
☐ *CHS/PRC* ☐ *Direct* ☐ _____

Legal Name:			**DOB:**
Preferred Name:	**Maiden/Other:**		
Birth Gender: ○F ○M	**Gender Identity:**		
Social Security #: - - (Last 4 only if updating)	**Marital Status** ☐**S** ☐**M** ☐**D** ☐**W** ☐**Other**		
Mailing Address:	☐ Unsheltered		☐No fixed Address
City:	**State:**	**Zip:**	**County:**
Physical Address:			
City:	**State:**	**Zip:**	**County:**
Preferred/Primary Phone #:	**Secure Voice Mail:** ☐ **YES**		
Secondary Phone #:	**Email:**		
Work Status: ○Full Time ○Part Time ○Retired ○Disabled ○Unemployed			
Employer Name:	**Phone:**		
Address:	**City:**	**State:**	**Zip:**
Student:☐k-12 ☐College ☐Full Time ☐Part Time	**Where:**		

☐ ***I have no other form of insurance .*** ***skip to page 2***

Primary Insurance Information

Medical Insurance:	**Phone:**	
Address:	**Eff Date:**	
Policy Holder : ○**Self** ○**Spouse** ○**Parent**	☐ **Purchased through Health Plan Finder**	
Name of Policy Holder (if other than self):	**DOB:**	
Social Security # (if other than self): - -		
ID #:	**Group #:**	
Dental Ins & ID#:	**RX Name/ID:**	
Optical Ins & ID#:		
Employer Name:	**Phone:**	

☐ ***I have no secondary insurance.*** ***skip to page 2***

Secondary Insurance/Medicare Advantage Information

Medical Insurance:	**Phone:**	
Address:	**Eff Date:**	
Policy Holder: ○**Self** ○**Spouse** ○**Parent**		
Name of Policy Holder (if other than self):	**DOB:**	
Social Security # (if other than self): - -		
ID#:	**Group#:**	
Dental Ins & ID#:	**RX Name/ID#:**	
Optical Ins & ID#:		
Employer Name:	**Phone:**	

Name of Tribe or Corporation:		
☐ Enrollment #:	☐ Non-Enrolled Descendant (supporting documentation required)	
Race/Ethnicity:	Language:	☐ A.S.L.

In Case of Emergency	
Name of Emergency Contact:	**Relationship:**
Address:	**Phone #:**

Legal Documents
Do you have legal documents that pertain to your health care? ☐YES ☐ NO
Please list and provide copies (advanced directives, power of attorney, living will, guardianship:

Veteran Status	
Are you a US Veteran? ☐YES (Thank you for your service)	**Entry Date:**
Do you have a service connected disability: ☐YES ☐NO	

Other Native Members of Household

Name(s) and Date of Birth:_____

_____

**** Authorizations ****

I have received a copy of the Notice of Privacy Practice.

I have received a copy of the Patient's Rights and Responsibilities.

My signature indicates, to the best of my knowledge, that all information provided on this application is true and accurate. My signature also authorizes the release of medical information necessary for diagnosis, treatment and billing. I also authorize payment of medical benefits either to myself or to the party who accepts assignment. I hereby assign benefits otherwise payable to me, to the Cowlitz Indian Tribe, Health Clinic.

Print Name:	**Signature:**
Relationship to Patient:	**Date:**

Please continue with application if you are a Cowlitz Tribal Member **I understand 42 CFR 136.23 mandates that I provide true and accurate information used to make an eligibility determination prior to approval of federal funds being expended on my behalf. I understand that information provided on my application may be verified to ensure compliance with federal law and the Cowlitz Tribe's Self Governance Agreement. I understand that providing false or incomplete information could result in non compliance with federal regulations, and to the best of my knowledge, I attest to the accuracy of the information submitted on this application. I understand 42 CFR 136.61 mandates that CHS/PRC is a payor of last resort and that I am required to apply for and utilize all alternate resources available to me. If I am un-insured or under-insured I will be required to submit an application for state medical/dental coverage and that I may only decline if there is a cost associated with accepting coverage. I am aware that as a Cowlitz Tribal Member I must maintain residency in the Tribe's designated service delivery to access federal funds. If I relocate I must notify the CHS/PRC program of my new residency. If I relocate to attend college and maintain status as a full time student I may remain eligible for CHS/PRC while in attendance. I am aware that demographic (phone/ address) information may be shared with or to Cowlitz Tribe, Enrollment Department if applicable.**

Cowlitz Members Name:	**Signature:**
Relationship to Patient:	**Date:**

We look forward to working with you and hope this year is filled with good health and wellness. Please let us know if you need additional assistance or have any questions.

PO Box 2429~Longview, WA 98632~ph: 360-575-8275 ~fax: 360-575-3304