Fond du Lac Human Services Division

Registration Form

For Office Use Only

Chart #_____

Patient Information – *Tribal policy requires us to complete a new form annually. Thank You.*

Name: _____ Other Name(s): _____

Last First Middle (Maiden)

Date of Birth: _____/_____/_____ Social Security Number: _____

Sex: ☐ Female ☐ Male Are you a Veteran? ☐ Yes ☐ No

Ethnicity: Hispanic or Latino ☐ Yes ☐ No

Race: (check all that may apply)

☐ American Indian/Alaska Native; ☐ African American; ☐ Caucasian; ☐ Asian; ☐ Native Hawaiian or Other Pacific Islander;

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: _____ Apt.: _____

City: _____ County: _____ State: _____ Zip: _____

Primary Contact Number: _____ Work Phone: _____

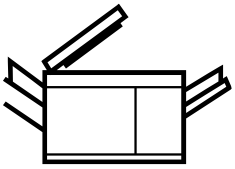
Cellular Phone Number: _____ Email: _____

Birth Mothers Name: _____

First Middle Last Maiden

What "Community" do you affiliate with? _____

Insurance & Employment Information:



Please give your insurance card to the Registration Clerk at the medical desk. We need to make a copy. If you do not have insurance, you may be asked to apply for Medical Assistance.

Employment Information ☐ Full time ☐ Part time

Employer Name: _____ Phone #: _____

Employer Address: _____ State: _____ Zip: _____

Occupation: _____

Full-time Student: ☐ No ☐ Yes If yes, are you covered by a parent's Health Insurance? _____

Primary Insurance:

Name of Insurance: _____ Effective Date: _____

Name of Policyholder: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Tribal Enrollment Information

American Indian/Alaskan Native: ☐ Yes (Need Enrollment Number if Yes) ☐ No

Name of Tribe Enrolled in: _____ Enrollment Number: _____

Descendant of American Indian/Alaskan Native: ☐ Yes ☐ No

☐ Parent (Need Courthouse Birth Certificate of patient with enrollee listed as parent)

☐ Grandparent (Need Courthouse Birth Certificate of patient AND parent's birth certificate linking to the Enrollee)

Name of Enrollee: _____ Enrollment Number: _____

Name of Tribe Enrolled in: _____

Non-Indian but meets one of the following requirements to be eligible to receive services:

☐ Has Fond du Lac Employee Insurance. (need copy of card) complete⇨	Policy holder Name Policy holder ID: Effective Date:
☐ Pregnant with an Indian Child. complete⇨ (Statement of Paternity required)	Father of Child: Date of Birth: Enrollment Number:
☐ Lives with a tribal member and is being seen for a contagious illness or Depression. complete⇨ (Proof of Indian Household form required)	Tribal Member's Name: Date of Birth: Enrollment Number:

Emergency Information

Emergency Contact: _____ Relationship: _____

Address: _____ Phone Number: _____

City: _____ County: _____ State: _____ Zip: _____

Relation: (*please check one)* ☐ Caregiver ☐ Emergency Contact ☐ Next of Kin

Responsible Party/Guarantor (a person that agrees to be responsible for another's debt; the person who pays the patient's bills)

☐ Self

Name: _____

Address: _____

Phone Number: _____

HIPAA PRIVACY RIGHTS (Please initial both boxes):

Initial

PRIVACY ACT OF 1974, P.L. 93-579. I understand that the information given by me and/or collected is necessary for the Fond du Lac Human Services staff or the IHS contractors to provide services for my health and well being. Furthermore, I have been informed that my health record or any portion of the record shall not be disclosed to another agency or person, unless specified as routine use (listed on the Why We Ask Questions" notice), or without my signed consent. I certify that the information given is true and correct.

Initial

HIPAA – I have been provided an opportunity to review FDL HSD HIPAA Privacy Policy (brochure available at registration desk).

Signature: _____ Date: _____

Signature of Staff Person accepting information: _____

Date Reviewed & Accepted by Staff Person: _____