Lassen Indian Health Center

Please DO NOT send personal information by email, as that is easily intercepted by people outside our clinic. You can print it out on paper and bring it to us, or mail it to:
LIHC Registration, 795 Joaquin Street, Susanville CA 96130.

Patient's full name: (Last, First Middle) _____

Patient's date of birth: _____ / _____ / _____ Chart:_____
Patient's sex: ☐ Male ☐ Female
Patient SSN: _____ - _____ - _____
Is the patient Native American? ☐ Yes ☐ No
Tribe of membership: _____
Tribal enrollment number: _____
Indian blood quantum: _____
Examples: 1/4, 5/128, FULL, unknown, unspecified
Additional tribal membership (if applicable):
_____
Present community: _____
Date moved to this community: _____ / _____ / _____
Marital Status: ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed
Place of birth: _____ (City) _____ (State)
Access to Internet: ☐ None ☐ Home ☐ Work ☐ School ☐ Library ☐ Health Care Facility ☐ Community Center ☐ Mobile Device
Patient mailing address: _____
Patient mailing city: _____
Patient mailing state: _____
Patient mailing zip code: _____
Patient street address: _____
Patient city: _____
Patient state: _____
Zip code: _____
Phone numbers: Residence: _____ - _____ - _____
Work: _____ - _____ - _____ **Other:** _____ - _____ - _____

Does this patient have:
Medicare coverage? ☐ Yes ☐ No
Medicaid coverage? ☐ Yes ☐ No
Railroad retirement coverage? ☐ Yes ☐ No
Private insurance coverage? ☐ Yes ☐ No

_____ (Policy#) _____ (Subscriber's Name) _____ (Subscriber's Date of Birth)

_____ (Policy#) _____ (Subscriber's Name) _____ (Subscriber's Date of Birth)

Religious preference: _____
Father's name: _____
Father's cell phone: _____
Father's other phone: _____
Father's email: _____
Father's city of birth: _____
Father's state of birth: _____
Father's employer name: _____
Mother's maiden name: _____
Mother's cell phone: _____
Mother's other phone: _____
Mother's email: _____
Mother's city of birth: _____
Mother's state of birth: _____
Mother's employer name: _____

Emergency contact name: _____
Emergency contact relationship: _____
(If Emergency Contact address is the patient's, enter SAME)
Emergency contact street address
_____
Emergency contact city: _____
Emergency contact state: _____
Emergency contact zip code: _____
Emergency contact phone number: _____ - _____ - _____
Patient's employer name: _____
Employment status: ☐ full-time ☐ part-time ☐ unemployed ☐ self employed ☐ retired ☐ active military duty
Spouse's employer name: _____
Spouse's employment status: ☐ full-time ☐ part-time ☐ unemployed ☐ self emp. ☐ retired ☐ active military duty
Name of next-of-kin (If same as emerg. contact, enter SAME):
_____
Next of kin relationship: _____
Next of kin street address: _____
Next of kin city: _____
Next of kin state: _____
Next of kin zip code: _____
Next of kin phone number: _____ - _____ - _____

Is the patient a veteran: ☐ Yes ☐ No

Ethnicity: ☐ Hispanic or Lanito ☐ Not Hispanic or Lanito

Race: ☐ American Indian or Alaska native ☐ Asian ☐ Black (not Hispanic or Latino) ☐ Filipino ☐ Native Hawaiian ☐ Pacific Islander ☐ White (not Hispanic or Latino)

Number in household: _____
Total household income: _____
Household income period: ☐ weekly ☐ monthly ☐ yearly
Primary language: _____

Migrant worker? ☐ No ☐ Migrant Agricultural Worker ☐ Seasonal Agricultural Worker

Homeless? ☐ No ☐ Homeless Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other

Reminders about appointments
☐ Please email me at: _____
☐ Please text me at: _____
☐ Please call me at: _____

SUSANVILLE INDIAN RANCHERIA

LASSEN INDIAN HEALTH CENTER

Patient's full name: (Last, First Middle) _____

Patient's date of birth: _____ / _____ / _____ Chart: _____

Even if you are here specifically for dental treatment, health problems you may have or medications you may be taking could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Medical History

Today's date: _____

Are you currently under another physician's care? ☐ Yes ☐ No

If **Yes**, please explain: _____

Do you use tobacco? ☐ Yes ☐ No _____

Do you use controlled substances? ☐ Yes ☐ No _____

Have you ever had serious back or neck injury? ☐ Yes ☐ No _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No _____

Do you take, or have you taken Phen-Fen or Redux? ☐ Yes ☐ No _____

Have you ever been hospitalized, or had a major operation ☐ Yes ☐ No _____

Primary reason for requesting a physical exam: _____

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

List all other drugs and substances to which you are allergic: _____

List all physicians, chiropractors, psychiatrists or psychologists who have treated you in the last 5 years: _____

Please list any prescription medications you take: _____

Please list any herbal, alternative medicine, vitamins, minerals, or over the counter remedies that you take: _____

Women, check any that apply: ☐Pregnant/trying to get pregnant ☐Nursing ☐Taking Oral Contraceptives ☐Menstrual problems

Patient History, check all that apply, now or in the past (family includes mother, father, grandparents, aunts and uncles)

Self	Family	None		Self	Family	None		Self	Family	None	
☐	☐	☐	AIDS/HIV positive	☐	☐	☐	Excessive bleeding	☐	☐	☐	Lung disease
☐	☐	☐	Alcohol use	☐	☐	☐	Excessive thirst	☐	☐	☐	Mitral valve prolapse
☐	☐	☐	Alzheimer's disease	☐	☐	☐	Eye problems	☐	☐	☐	Multiple sclerosis
☐	☐	☐	Anaphylaxis	☐	☐	☐	Fainting spells/dizziness	☐	☐	☐	Osteoporosis
☐	☐	☐	Anemia	☐	☐	☐	Fracture	☐	☐	☐	Pain in jaw joints
☐	☐	☐	Angina	☐	☐	☐	Frequent cough	☐	☐	☐	Parathyroid disease
☐	☐	☐	Anxiety	☐	☐	☐	Frequent diarrhea	☐	☐	☐	Prostate problems
☐	☐	☐	Artificial Joint	☐	☐	☐	Frequent headaches	☐	☐	☐	Psychiatric care
☐	☐	☐	Asthma	☐	☐	☐	Frequent UTI (bladder infection)	☐	☐	☐	Psychological problems
☐	☐	☐	Arthritis/Gout	☐	☐	☐	Genital herpes	☐	☐	☐	Radiation treatments
☐	☐	☐	Artificial Heart Valve	☐	☐	☐	Glaucoma	☐	☐	☐	Recent weight loss
☐	☐	☐	Blood clots	☐	☐	☐	Hay fever	☐	☐	☐	Renal dialysis
☐	☐	☐	Blood disease	☐	☐	☐	Heart attack/failure	☐	☐	☐	Rheumatic fever
☐	☐	☐	Blood transfusion	☐	☐	☐	Heart murmur	☐	☐	☐	Rheumatism
☐	☐	☐	Breathing problem	☐	☐	☐	Heart pacemaker	☐	☐	☐	Scarlet fever
☐	☐	☐	Bruise easily	☐	☐	☐	Heart trouble/disease	☐	☐	☐	Shingles
☐	☐	☐	Cancer	☐	☐	☐	Hemophilia	☐	☐	☐	Sickle cell disease
☐	☐	☐	Chemotherapy	☐	☐	☐	Hepatitis A	☐	☐	☐	Sinus trouble
☐	☐	☐	Chest pains	☐	☐	☐	Hepatitis B or C	☐	☐	☐	Spina bifida
☐	☐	☐	Cold sores/fever blisters	☐	☐	☐	Herpes	☐	☐	☐	Stroke
☐	☐	☐	Congenital heart disorder	☐	☐	☐	High blood pressure	☐	☐	☐	Swelling of limbs
☐	☐	☐	Convulsions	☐	☐	☐	High cholesterol	☐	☐	☐	Thyroid disease
☐	☐	☐	COPD	☐	☐	☐	Hives or rash	☐	☐	☐	Tonsillitis
☐	☐	☐	Cortisone medicine	☐	☐	☐	Hypoglycemia	☐	☐	☐	Tuberculosis
☐	☐	☐	Depression	☐	☐	☐	Intestinal/stomach disease	☐	☐	☐	Tuberculosis, Positive Test
☐	☐	☐	Diabetes	☐	☐	☐	Irregular heartbeat	☐	☐	☐	Tumors or growths
☐	☐	☐	Domestic violence	☐	☐	☐	Kidney disease	☐	☐	☐	Ulcers
☐	☐	☐	Drug dependence or addiction	☐	☐	☐	Kidney problems	☐	☐	☐	Venereal disease
☐	☐	☐	Easily winded	☐	☐	☐	Leukemia	☐	☐	☐	Yellow jaundice
☐	☐	☐	Emphysema	☐	☐	☐	Liver disease	Other: _____			
☐	☐	☐	Epilepsy or seizures	☐	☐	☐	Low blood pressure	_____			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the health center of any changes in medical status.

_____ Signature of Patient or Parent/Legal Representative

_____ Relationship to Patient

_____ Date

Patient's full name: (Last, First Middle) _____

Patient's date of birth: _____ / _____ / _____ Chart: _____

PATIENT GENERAL CONSENT

This agreement is entered into by and between Lassen Indian Health Center and the Patient.
The agreement is entered into in order for the client to bill available sources for those services rendered and to permit the release of information from the client's records to insurers and others who may care for him or her in the future.

Terms of Agreement

1. **THE AGREEMENT AUTHORIZATION**: The patient or responsible relative agent or guardian authorizes Lassen Indian Health Centers Physicians, Dentists and/or Mental Health professionals to treat him/her according to treatment plan(s) presented.
2. **AUTHORIZATION TO PAY:** Patient authorizes Lassen Indian Health Center to receive direct payment for services rendered from appropriate payment sources. Charges will not exceed that which is reasonable and customary.
3. **RELEASE OF INFORMATION:** Patient gives permission to Lassen Indian Health Center to release information concerning him/her to insurer and other agencies for the purpose of billing, and other individuals who may provide medical or social services to the patient.
4. **CLIENT RIGHTS:** Patient rights have been read/explained to the patient's satisfaction by Lassen Indian Health Center staff.
5. **AUTHORIZATION FOR THE TREATMENT OF A MINOR CHILD:** It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all physicians, dentists, or mental health professionals in the exercise of their best judgment that may seem advisable.
6. **CERTIFICATION:** The Patient, responsibly relative, guardian or agent, certifies that he/she has read the aforesaid, is willing to abide by these agreements and all questions have been answered to my satisfaction concerning treatment at Lassen Indian Health Center.

_____ _____ _____
Signature of Patient or Parent/Legal Representative | Relationship to Patient | Date

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ACKNOWLEDGEMENT OF POLICIES, PRIVACY PRACTICES (HIPPA) & PATIENT RIGHTS AND RESPONSIBILITIES

I _____, acknowledge the following:
Patient, Patient Representative, Guardian or Agent

- ☐ I give permission to LIHC to release my information for billing purposes
- ☐ For the purposes of collection of 3rd party billing, I assign my benefits to LIHC
- ☐ I have been provided a ***Notice of Privacy Practices*** (HIPPA) pamphlet to read
- ☐ I have been provided the ***Patient Rights and responsibilities*** to read
- ☐ I have been provided ***Lassen Indian Health Center Policies*** to read
- ☐ I have been provided ***Dental Material Fact Sheet*** to read
- ☐ I understand I can request copies of the above information from Lassen Indian Health Center

_____ _____ _____
Signature of Patient or Parent/Legal Representative | Relationship to Patient | Date

SUSANVILLE INDIAN RANCHERIA

LASSEN INDIAN HEALTH CENTER

Patient's full name: (Last, First Middle) _____

Patient's date of birth: _____ / _____ / _____ Chart: _____

LIMITS OF CONFIDENTIALITY

Information discussed during health visits at Lassen Indian Health Center is held confidential and not shared with anyone without written permission except under the following conditions:

1. If the patient threatens suicide
2. If the patient threatens to harm another person(s), including murder, assault, or other physical harm
3. If the patient reports suspected child abuse, including but not limited to physical beatings or sexual abuse
4. If the patient reports abuse of the elderly
5. If the patient reports sexual exploitation by another health care or mental health professional

State and Federal law mandates that health care and mental health care professionals may need to report these situations to the proper authorities and/or agencies (see 42 U.S.C. 290ee-3, 290ff-3, for federal laws and CCR part 2 for federal regulations).

Communication between you and your health care or mental health professional will otherwise be confidential under State and Federal Law.

I have read and understand the above.

_____ _____ _____

Signature of Patient or Parent/Legal Representative | Relationship to Patient | Date

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CLIENT CONTRACT TO MEET FEDERAL INSURANCE REQUIREMENTS (for Native American patients)

I understand that it is mandatory to seek Medi-Cal, Medicare, County or any other insurance to pay medical, dental or mental health bills. Federal law requires that I seek insurance before IHS (Indian Health Service) payment. I must seek insurance within the same month I use Lassen Indian Health Center, or be denied services that are not acute or emergent. I will gain an appointment to seek insurance by, _____(Date).

Please answer the following by checking the appropriate answer

I will require assistance to complete the forms. ☐ Yes ☐ No
I do not have adequate transportation to seek insurance. ☐ Yes ☐ No
I request more explanation. ☐ Yes ☐ No

I understand that if I do not follow up on seeking insurance, I may be denied services at Lassen Indian Health Center.

I will bring Medi-Cal and/or insurance information to all appointments.

_____ _____ _____

Signature of Patient or Parent/Legal Representative | Relationship to Patient | Date

LASSEN INDIAN HEALTH CENTER

Patient's full name: (Last, First Middle) _____

Patient's date of birth: _____ / _____ / _____ Chart: _____

Patient Address:_____ Patient Phone: _____

_____

RELEASE OF CONFIDENTIAL INFORMATION FORM

Name of Person requesting information:_____

Relationship to Patient: _____

Note: Patient records are only released to the patient (SELF) and in some cases of minor children, to parents or legal guardians. An appropriately completed POWER OF ATTORNEY will be required for the release of information for any other patient. *I authorize the release for information from:*

_____
Name of Doctor/Facility

_____
Address

_____
City State Zip code

_____
Phone FAX

To: **Lassen Indian Health Center**

I CONSENT TO AND AUTHORIZE, the release of information regarding (check all that apply):

☐ Medical Records ☐ Dental Records ☐ Other

To Include:

☐ Chart notes ☐ Lab results ☐ X-rays

☐ Medical History ☐ Physical Exam ☐ Other

Dates of Service / Records requested: _____

Federal regulations prevent the release of the following three (3) areas of information unless specific written consent is given to the release thereof. The following three (3) areas of information will not be disclosed unless properly initialed.

NOTE TO CLIENTS COMPLETING THIS PORTION OF THE FORM: By **initialing** any one (1) of the following, you are giving specific written consent for the release of information related to that area. (PLEASE INITIAL)

_____ Mental Health records
(Includes information related to mental health, development or psychiatric conditions)

_____ Drug and Alcohol Records
(Includes information related to alcoholism, other drug addiction, or other substance abuse disorders)

_____ HIV (Human Immunodeficiency Virus), AIDS (Acquired Immune Deficiency Syndrome), and/or ARC (Aids Related Complex) status or treatment.

Dates of Service / Records requested: _____

THIS AUTHORIZATION WILL BE VALID FOR ONE (1) YEAR FROM DATE SIGNED. I UNDERSTAND I MAY REVOKE THIS CONSENT AT ANYTIME, EXCEPT TO THE EXTENT WHERE ACTION HAS ALREADY BEEN TAKEN.

_____ _____ _____
Signature of Patient or Parent/Legal Representative Relationship to Patient Date

LASSEN INDIAN HEALTH CENTER

Patient's full name: (Last, First Middle) _____

Patient's date of birth: _____ / _____ / _____ Chart: _____

COORDINATING CARE CONSENT: Communicating With Family & Others

Please List any family members or others who may be involved in coordinating your care or payment for your care. Also indicate what type of information may be share with each individual.

Name	Relationship to Patient	Type of information to be shared			
		Medical	Dental	Scheduling & Appointments	Billing & Insurance

Specific Instructions or Limitations: _____

Validation Code: _____

Please provide this code to any individual who may be involved in coordinating your care or payment for your care. They will be asked for this code before information can be released over the telephone. We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Promptly notify our office staff if you wish to alter any of the above designations.

_____ _____ _____

Signature of Patient or Parent/Legal Representative | Relationship to Patient | Date

To revoke this authorization, please send written notice to 795 Joaquin Street, Susanville CA 96130. For questions call (530)257-2542

AUTHORIZATION AND CONSENT FOR THE TREATMENT OF A MINOR CHILD

I (we) as parent(s) and/or legal guardian(s) do hereby authorize consent for the Lassen Indian Health Center to arrange for or to provide the following services:

1. Health care including medical examinations, routine laboratory studies, x-ray procedures and skin tests
2. Dental care including dental examinations, preventative use of fluorides, and necessary emergency medical care
3. Mental Health and Substance Use Disorder (S.U.D.) services including evaluation and treatment as necessary
4. Transportation of the child to or from another Health Facility for these services

Exceptions or special instructions:_____

_____

I hereby give consent for all of the above services.

This authorization shall remain effective for one year from date signed, unless revoked sooner in writing by parent or legal guardian and delivered to the Lassen Indian Health Center.

This authorization is given pursuant the provisions of § 25.8 of the Civil Code of California

_____ _____ _____

Signature of Parent/Legal Representative | Relationship to Patient | Date

To revoke this authorization, please send written notice to 795 Joaquin Street, Susanville CA 96130. For questions call (530)257-2542

LASSEN INDIAN HEALTH CENTER

Patient's full name: (Last, First Middle) _____

Patient's date of birth: _____ / _____ / _____ Chart: _____

TB Screening Questionnaire

Yes	No	
☐	☐	Have you ever had a positive TB skin test?
☐	☐	Have you ever had a severe reaction to a TB skin test?
☐	☐	Have you ever taken medication for TB?

Where were you born?_____

If born outside the USA, when did you come here? _____

In the past 12 months, have you:

Yes	No	Don't know	
☐	☐	☐	Lived with or had close contact with someone who had active TB
☐	☐	☐	Worked with patients with TB
☐	☐	☐	Volunteered or lived in a group home jail, homeless shelter or other group institution
☐	☐	☐	Been told by a health professional you have TB
☐	☐	☐	Been told by a health professional your immune system is not working right/ you cannot fight infection

In the past 12 months, have you had:

Yes	No	Don't know	
☐	☐	☐	A persistent cough for 3+ weeks
☐	☐	☐	Coughed up blood
☐	☐	☐	Unexplained, excessive fatigue
☐	☐	☐	Unexplained excessive sweating at night
☐	☐	☐	Unexplained recurring fevers for 3+ weeks
☐	☐	☐	Unexplained weight loss
☐	☐	☐	Hoarseness for 3+ weeks
☐	☐	☐	Pneumonia