New Patient Registration Packet Checklist

Welcome to our clinic! Below you will find a checklist to help you complete the registration packet and ensure that you will have everything you need to bring to your first appointment. The registration packet will only be considered complete when all verifications are provided.

Verifications Needed

- [ ] Identification Card (ID)
- [ ] Insurance Cards
- [ ] Proof of Tribal Enrollment (If Applicable)

Forms to Complete

- [ ] Patient Registration
- [ ] Health History
- [ ] TB Screening Questionnaire
- [ ] Financial Agreement & Policies
- [ ] Patient Consent & Limits of Confidentiality
- [ ] Coordinating Care Consent
- [ ] Records Release Form
- [ ] Consent for the Treatment of a Minor

LASSEN INDIAN HEALTH CENTER

Patient Registration

We are pleased to welcome you to our clinic. Please take a few minutes to complete this form. If you have any questions, we'll be glad to help you.

1. Patient Information

Last Name _____ First Name _____ MI _____ Email Address _____

Date of Birth _____ Place of Birth _____ Date When Moved to County _____ Social Security # _____

Gender: ☐ Female ☐ Male ☐ Transgender **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ☐ Hispanic ☐ Non-Hispanic or Latin

Race:
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White/Caucasian
- ☐ Asian
- ☐ Unknown

Spoken Language: _____

How well do you speak English?
- ☐ Very Well
- ☐ Well
- ☐ Not Well
- ☐ Not at all

2. Tribal Membership Information

Tribe of Membership _____ Roll Number _____ Certificate of Indian Blood (CIB) _____ State Where Enrolled _____

3. U.S. Veteran Status

Are you a U.S. Veteran? ☐ Yes ☐ No Service Entry Date _____ Service Separation Date _____ Vietnam Service _____

4. Home Address & Phone

Check this box if information is the same for the entire family: ☐

Home Address _____ City _____ State _____ Zip _____ Phone _____

Mailing Address same as above ☐ *Mailing* Address _____ City _____ State _____ Zip _____

5. Employment Status

☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Student

Occupation _____ Employer Name _____ Employer Address _____

6. Emergency Contact

Who should we call in case of an emergency?

First Name _____ Last Name _____ Phone _____ Relationship _____

7. Minor Contact

If the patient is a minor, please indicate the following family information.

(Father) First Name, Last Name _____ Place of Birth (City & State) _____

(Mother) First Name, Last Name _____ Place of Birth (City & State) _____ Mother's Maiden Name _____

8. Contact Preferences

How would you like us to contact you about your appointments? ☐ Home Phone ☐ Work Phone ☐ Cell ☐ Email

Do you have internet access? ☐ Yes ☐ No What kind of internet access do you have? ☐ Home Access ☐ Mobile

Would you like to have communications sent to you via email? (i.e. appointment reminders, updates, bulletins) ☐ Yes ☐ No

How did you hear about us? _____

9. Guarantor Information

Please complete if you are the parent or another party responsible for paying the bill.

First Name (Guarantor) _____ Last Name (Guarantor) _____ Home Phone _____ Language _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____ Email Address _____

Occupation _____ Employer Name _____ Employer Address _____

Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian/Conservator

10. **Medical** Insurance Information

a. Primary Insurance

Subscriber Name _____ Subscriber ID# _____

Social Security # _____ Date of Birth _____

Insurance Company _____ Insurance Phone # _____

Group Name _____ Group # _____

Employer _____ Relationship to Subscriber _____

b. Secondary Insurance

Subscriber Name _____ Subscriber ID# _____

Social Security # _____ Date of Birth _____

Insurance Company _____ Insurance Phone # _____

Group Name _____ Group # _____

Employer _____ Relationship to Subscriber _____

**Please present insurance card to receptionist*

11. **Dental** Insurance Information

a. Primary Insurance

Subscriber Name _____ Subscriber ID# _____

Social Security # _____ Date of Birth _____

Insurance Company _____ Insurance Phone # _____

Group Name _____ Group # _____

Employer _____ Relationship to Subscriber _____

b. Secondary Insurance

Subscriber Name _____ Subscriber ID# _____

Social Security # _____ Date of Birth _____

Insurance Company _____ Insurance Phone # _____

Group Name _____ Group # _____

Employer _____ Relationship to Subscriber _____

**Please present insurance card to receptionist*

12. Acknowledgment

Is your visit due to a job-related injury or automobile accident? ☐ Yes ☐ No

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to LIHC. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Name of Patient (or Guardian) *(print)* _____ Signature _____ Date _____

Official Use Only:

Proof of Guardianship Received ☐ Yes ☐ No

Scanned/Copied to Chart ☐ ☐

Signature of Witness _____ Date _____

LASSEN INDIAN HEALTH CENTER

Health History

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 care you receive.

Patient's Name: *(Last, First Middle)*_____ Date of Birth: _____ Today's Date: _____ Chart: _____

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

LASSEN INDIAN HEALTH CENTER

Tuberculosis (TB) Screening

This questionnaire will better help to identify possible exposure to tuberculosis or symptoms that might indicate a TB infection. Please check all that apply.

1. Patient Information

_____ _____ _____ _____

Last Name | First Name | Middle | Date of Birth

2. Testing & Medication

- ☐ Have you ever had a positive TB skin test?
- ☐ Have you ever had a sever reaction to a TB skin test?
- ☐ Have you ever taken medication for TB?

3. Contact & Potential Exposure

In the past 12 months, have you:

- ☐ Worked with patients with TB
- ☐ Lived with or had close contact with someone who had active 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

4. Geographic Location

- ☐ Were you born outside of the US?
  If so, where were you born and when did you arrive?

_____ _____

Country of Birth | Date of Arrival to US

5. Signs & Symptoms

In the past 12 months, have you had:

- ☐ A persistent cough for 3+ weeks
- ☐ Coughed up blood
- ☐ Unexplained, excessive fatigue
- ☐ Unexplained recurring fevers for 3+ weeks
- ☐ Unexplained weight loss
- ☐ Hoarseness for 3+ weeks
- ☐ Pneumonia

LASSEN INDIAN HEALTH CENTER

Financial Agreement & Policies

Quality care for our patients is our priority. Please take a few minutes to review our financial agreement and policies and sign at the bottom of the form.

1. Patient Information

Last Name	First Name	Middle	Date of Birth
_____	_____	_____	_____

2. Client Contract to Meet Federal Insurance Requirements

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 Indian Health Service (IHS) payment. I must seek insurance within the same month that 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 the following date: _____.

Please check any of the following that apply:

- ☐ I require assistance to complete the forms
- ☐ I do not have adequate transportation to seek insurance
- ☐ I request further explanation

3. Appointment & No-Show Policy

The professional staff at Lassen Indian Health Center provide medical and dental services for the entire Susanville community. The licensed providers and their respective staff have developed systems for treating all those who need help. In order to effectively treat each and every person needing help, office polices have been developed to expedite the flow of patients through the respective clinics.

It is imperative that each patient call for an appointment. If you cannot make an appointment, a 24-hour cancellation notice must be given, or it will be considered a no-show. If you arrive 10 minutes after your scheduled appointment, the appointment will be rescheduled and it will be considered a no-show.

No-shows are recorded and the appointment will need to be rescheduled. A second no-show will result in the patient being placed at the bottom of our waitlist. After the third no-show, no further appointments can be scheduled for the remainder of the year and only emergency treatment will be available. Emergency treatment consists of only antibiotics and our choice of possible pain medication.

We appreciate your understanding and consideration regarding our appointment and no-show policy and if you have any questions, please do not hesitate to ask us.

4. Acknowledgment & Agreement

I have read and understood the Federal Insurance Requirements and Appointment & No-Show Policy as described above. 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 other insurance information to all appointments.

Name of Patient (or Guardian) *(please print)*	Signature	Date
_____	_____	_____

LASSEN INDIAN HEALTH CENTER

Patient Consent & Limits of Confidentiality

This agreement is entered into by and between Lassen Indian Health Center and the patient in order to be able to bill available sources for services rendered and to allow for the release of information from the patient's records to the insurance companies and/or others who may be involved in caring for the patient in the future.

1. Patient Information

Last Name	First Name	Middle	Date of Birth
_____	_____	_____	_____

2. Patient Consent

- ✓ **The Agreement Authorization:** The patient or responsible party authorizes the providers at Lassen Indian Health Center to render treatment according to the treatment plan created for the patient.
- ✓ **Authorization to Pay:** The patient authorizes Lassen Indian Health Center to receive direct payment for services rendered from the appropriate payment sources. Charges will not exceed that which is reasonable and customary.
- ✓ **Release of Information:** The patient gives permission to Lassen Indian Health Center to release information to the insurer or other agencies for the purpose of billing as well as to other individuals who may provide additional healthcare, dental care, or social services to the patient.
- ✓ **Client Rights:** Patient rights have been read/explained to the patient's satisfaction by the Lassen Indian Health Center staff.
- ✓ **Authorization for the Treatment of a Minor:** 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 judgement that may seem advisable.
- ✓ **Certification:** The patient, responsible relative, guardian or agent, certifies that they have read the terms of agreement, are willing to abide by the agreement, and have had all of their questions answered satisfactorily concerning treatment at Lassen Indian Health Center.

3. 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, 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 healthcare or mental health professional*

State and Federal Law mandate that healthcare 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, for Federal Laws and CCR part 2 for Federal Regulations). Communication between you and your healthcare or mental health professional will otherwise be confidential under State and Federal Law.

4. Acknowledgment & Agreement

Please place a checkmark next to the following statements to indicate that you agree and then sign below.

- ☐ I give permission to LIHC to release my information for billing purposes.
- ☐ For the purposes of collection of third-party billing, I assign my benefits to LIHC.
- ☐ I have been provided the ***Notice of Privacy Practices***, ***Patient Rights & Responsibilities***, ***Financial Agreement & Policies*** and the ***Dental Materials Fact Sheet*** to read.
- ☐ I understand that I can request copies of the above information from Lassen Indian Health Center.

I authorize the release of any medical information necessary to process bills to my insurance company, and request payment of benefits to Lassen Indian Health Center. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Name of Patient (or Guardian) *(print)*	Signature	Date
_____	_____	_____

LASSEN INDIAN HEALTH CENTER

Coordinating Care Consent

Please list any family members or others who may be involved in coordinating care or payment for care. Please indicate what type of information may be shared.

1. Patient Information

_____ _____ _____ _____

Last Name | First Name | Middle | Date of Birth

2. Family Members or Others Involved in Care

		Indicate the Type of Information to be Shared			
Name	Relationship to Patient	Medical	Dental	Scheduling & Appointments	Billing & Insurance
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐

Specific instructions or limitations: _____

3. Validation Code

Please provide a validation code to any individual who may be involved in coordinating care or payment. You will be asked for this code before information can be released over the phone.

Validation Code: _____

4. Review & Consent

We will continue to use the information on this form when communicating with family members or others involved in your care unless you make changes. Promptly notify our office staff if you wish to alter any of the above designations. To revoke this authorization, please send written notice to 795 Joaquin Street, Susanville CA 96130.

_____ _____ _____

Signature of patient/parent/guardian | Relationship to Patient | Date

LASSEN INDIAN HEALTH CENTER

Health Records Release Form

Filling out this form will give Lassen Indian Health Center permission to use or release your protected health information with the person, organization, or facility of your choosing. Please complete all sections below.

1. Patient Information

_____ _____ _____ _____

Last Name | First Name | Middle | Date of Birth

2. Who is making the request?

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.

_____ _____

Name of Person requesting records release | Relationship to patient

3. Records will be released from:

I authorize the release of information from:

_____ _____ _____

Name of Doctor/Facility | Phone | Fax

_____ _____ _____ _____

Address | City | State | Zip

4. Records will be released to:

Lassen Indian Health Center

5. Specific information to be released:

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: _____

5. Optional Information to be released:

Federal regulations prevent the release of the following three (3) areas of information unless specific written consent is given for 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 consent for the release of information related to that area.

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

_____ Drug and Alcohol Records (Includes information related to alcoholism, 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.

6. Acknowledgment & Agreement

This authorization will be valid for one year from date signed. I understand I may revoke this consent at any time, except to the extent where action has already been taken.

_____ _____ _____

Name of Patient (or Guardian) *(please print)* | Signature | Date

LASSEN INDIAN HEALTH CENTER

Consent for Treatment of Minor

The treatment of a minor requires the unified efforts of the healthcare provider and parent or legal guardian of the child. The role of the provider is to ensure that the parent or guardian is aware of and agrees with the treatment plan.

1. Patient Information

Last Name	First Name	Middle	Date of Birth
_____	_____	_____	_____

2. Authorization & Consent for the Treatment of a Minor

The parent or legal guardian authorizes consent for Lassen Indian Health Center to arrange for or provide the following services:

1. **Healthcare** 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 care
3. **Mental Health** and Substance Use Disorder (S.U.D.) services including evaluation and treatment as necessary
4. **Transportation** of the child to and from another Health Facility for these services

Exceptions or special instructions: _____

_____

3. Acknowledgment & Agreement

I hereby give consent for all of the above services. This authorization shall remain effective for one year from the date signed, unless revoked sooner in writing by parent or legal guardian and delivered to Lassen Indian Health Center. This authorization is given pursuant the provisions of article 25.8 of the Civil Code of California. To revoke this authorization, please send written notice to 795 Joaquin Street, Susanville CA 96130.

Name of Patient or Parent/Legal Representative *(print)*	Signature	Date
_____	_____	_____