



# LASSEN

INDIAN HEALTH CENTER

## 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. *Please ensure that all information is either typed or written in blue or black ink and that signatures are completed by hand, as no electronic signatures can be accepted.*

### 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
- Consent for AI-Assisted Medical Charting

*\*We are not a Workers' Compensation provider and should your insurance result as denied, you will be held financially responsible for your bill.*



# 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  Yes  No

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_



# 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

Alcohol use

Alzheimer's disease

Anaphylaxis

Anemia

Angina

Anxiety

Artificial Joint

Asthma

Arthritis/Gout

Artificial Heart Valve

Blood clots

Blood disease

Blood transfusion

Breathing problem

Bruise easily

Cancer

Chemotherapy

Chest pains

Cold sores/fever blisters

Congenital heart disorder

Convulsions

COPD

Cortisone medicine

Depression

Diabetes

Domestic violence

Drug dependence or addiction

Easily winded

Emphysema

Epilepsy or seizures

Excessive bleeding

Excessive thirst

Eye problems

Fainting spells/dizziness

Fracture

Frequent cough

Frequent diarrhea

Frequent headaches

Frequent UTI (bladder infection)

Genital herpes

Glaucoma

Hay fever

Heart attack/failure

Heart murmur

Heart pacemaker

Heart trouble/disease

Hemophilia

Hepatitis A

Hepatitis B or C

Herpes

High blood pressure

High cholesterol

Hives or rash

Hypoglycemia

Intestinal/stomach disease

Irregular heartbeat

Kidney disease

Kidney problems

Leukemia

Liver disease

Low blood pressure

Lung disease

Mitral valve prolapse

Multiple sclerosis

Osteoporosis

Pain in jaw joints

Parathyroid disease

Prostate problems

Psychiatric care

Psychological problems

Radiation treatments

Recent weight loss

Renal dialysis

Rheumatic fever

Rheumatism

Scarlet fever

Shingles

Sickle cell disease

Sinus trouble

Spina bifida

Stroke

Swelling of limbs

Thyroid disease

Tonsillitis

Tuberculosis

Tuberculosis, Positive Test

Tumors or growths

Ulcers

Venereal disease

Yellow jaundice

Other: \_\_\_\_\_

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



## 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 severe reaction to a TB skin test?
- Have you ever taken medication for TB?

### 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

### 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

### 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



## 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.

To effectively treat each and every person needing help, office policies 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, please notify the office as soon as you are aware. If notice is given less than one hour prior to the scheduled appointment time, it will be considered a same-day cancellation. If you miss your appointment or arrive 10 minutes after your scheduled appointment, the appointment will be considered a no-show and will need to be rescheduled.

Same-day cancellations and no-shows are recorded. After the third no-show in a six-month period, all future appointments will be canceled, and no further appointments can be scheduled for 3 months. The patient may only be seen on a walk-in basis based off medical necessity. If there is an excessive occurrence of same-day cancellations, the patient may also be moved to a walk-in basis.

### 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



# 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



## 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
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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?      Continuation of Care      Personal Records

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 coming from:

Lassen Indian Health Center       Other Facility

\_\_\_\_\_  
Facility/Doctor Name

\_\_\_\_\_  
Phone                                      Fax

\_\_\_\_\_  
Address

### 4. Records going to:

Lassen Indian Health Center       Other Facility

\_\_\_\_\_  
Facility/Doctor Name

\_\_\_\_\_  
Phone                                      Fax

\_\_\_\_\_  
Address

### 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 \_\_\_\_\_

Information released can include the following (check all that apply):

- Chart Notes
- Lab Results
- Medication History
- Medical History
- X-Rays
- Physical Exam
- Other \_\_\_\_\_

Dates of service/records requested: \_\_\_\_\_

### 6. 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.

**EACH CONSENT LINE MUST BE INITIALED TO BE CONSIDERED VALID.**

\_\_\_\_\_ 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.

### 7. 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



## 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

### *Official Use Only:*

Scanned/Copied to Chart by:

\_\_\_\_\_

Employee Name

\_\_\_\_\_

Date



## 1. Purpose of this Authorization

I understand that my healthcare provider uses Dragon Medical One recognition software to assist with the creation of my medical record. This technology is used to convert spoken words into text during my appointment. The purpose of this is to increase the efficiency and accuracy of my medical record documentation.

## 2. How Dragon Speech Recognition Works

During my medical appointment, the AI assistant will listen during the visit. It will create a draft of your medical note and then the provider reviews the notes for accuracy before finalizing them.

I understand that the Dragon software will not be used to make any decisions about my care. My provider remains responsible for all aspects of my treatment.

## 3. Protection of Patient Information

Our medical practice and its technology partners, Microsoft/Nuance, use robust security measures to protect the confidentiality and integrity of my health information.

These measures include:

- Secure encryption of voice data during transit and storage.
- Protection of my data in compliance with HIPAA regulations.
- Access controls to prevent unauthorized access.

I understand that any voice data used for speech recognition is processed securely, and my identifying information is protected.

## 4. Patient Rights

Patients have the right to request access to and amendments of their medical records, including associated transcripts generated by speech recognition software. Patients can also withdraw their consent for the use of this technology at any time without affecting the quality of their care. If consent is withdrawn, an alternative method of documentation will be used.

## 5. Acknowledgment & Consent

By signing the form, the patient consents to the use of Dragon AI-assisted recognition software for medical record documentation after reading and understanding the information provided.

\_\_\_\_\_  
Name of Patient (or Guardian) *(please print)*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date