WHITE EARTH HEALTH CENTER PATIENT MINI REGISTRATION - #_____

NAME_____
LAST FIRST MIDDLE

BIRTHDATE_____PLACE OF BIRTH_____ SEX: F M

SOCIAL SECURITY #_____

MAILING ADDRESS_____
BOX/STREET CITY STATE ZIP CODE

TELEPHONE #_____

TRIBE_____ ENROLLED? Y N ENROLL# _____

DESCENDENT? Y N BLOOD QUANTUM_____(NEED PROOF OF DESC OR ENROLLMENT)

MA/GA/HMO: Y N POLICY # _____ EFFECT DATE_____

HEALTH INSURANCE: POLICY # _____ EFFECT DATE_____
NAME OF INSURANCE:_____ (NEED A COPY OF INSURANCE CARD)

FATHER'S NAME _____ PLACE OF BIRTH _____

MOTHER'S MAIDEN AND FIRST NAME _____ PLACE OF BIRTH _____

EMERGENCY CONTACT _____
NAME RELATIONSHIP TO PATIENT
ADDRESS:_____ TELEPHONE # _____

I UNDERSTAND THAT THE INFORMATION GIVEN BY ME AND/OR COLLECTED IS NECESSARY FOR THE INDIAN HEALTH SERVICE STAFF OR I.H.S. CONTRACTORS TO PROVIDE SERVICES FOR MY HEALTH AND WELL BEING.

I HEREBY ASSIGN TO THE I.H.S. INSURANCE BENEFITS (IF ANY) THAT I MAY HAVE PERTAINING TO PAYMENT FOR MEDICAL SERVICES AND SUPPLIES FURNISHED TO ME BY I.H.S. I AUTHORIZE PAYMENT OF SUCH BENEFITS DIRECTLY TO I.H.S. I UNDERSTAND THAT IF ANY PAYMENTS GO DIRECTLY TO ME THAT I MUST TURN THEM IN TO THE WHITE EARTH CENTER BUSINESS OFFICE.

I CERTIFY THAT THE INFORMATION IS TRUE AND ACCURATE.

SIGNATURE: DATE: