**\*\*\*White Earth Indian Health Center\*\*\***

**New Patient Registration HRN#**

**NAME: OTHER NAMES USED:**

**LAST, FIRST MIDDLE MAIDEN**

**SOCIAL SECURITY # BIRTHDATE: SEX: F M**

**MARITAL STATUS RACE: LANGUAGE:**

**RACE: TRIBE: ENROLLED: Y N ENROLL#**

**DESCENDENT: Y N BLOOD QUANTUM: (NEED PROOF OF DESC OR ENROLLMENT)**

**ADDRESS:**

**PO BOX & PHYSICAL CITY STATE ZIP CODE**

**COUNTY: DATE MOVED TO CURRENT ADDRESS:**

**PHONE #: WORK #: CELL#:**

**PLACE OF BIRTH: HOMELESS: Y/ N LANGUAGE:**

**CITY/STATE**

**EMPLOYER (PARENTS): FT/PT**

**FATHERS NAME: PLACE OF BIRTH:**

**MOTHERS (MAIDEN) NAME: PLACE OF BIRTH:**

**EMERGENCY CONTACT: RELATIONSHIP:**

**ADDRESS: PHONE #:**

**NEXT OF KIN: RELATIONSHIP:**

**ADDRESS: PHONE:**

**MEDICARE: Y N POLICY #: EFFECTIVE DATE:**

**MN MA/ND MA/HMO: Y N POLICY #: EFFECTIVE DATE:**

**HEALTH INSURANCE: Y N POLICY #: EFFECTIVE DATE:**

**INSURANCE COMPANY: (NEED COPY OF INSURANCE CARD)**

**MILITARY SERVICE: Y N BRANCH: SERVICE DATE(S):**

**I understand the information given by me and/or collected is necessary for the Indian Health Service Staff to provide services for my health and well-being.**

**I hereby assign to the IHS Insurance Benefits (if any) that I may have pertaining to payment for medical services and payment go directly to me that I must turn them in to the White Earth Health Center Business Office.**

**I certify that the information is true and accurate.**

**Signature: Date:**