CHEROKEE NATION HEALTH SERVICES
REGISTRATION AND CONSENT FOR COMMUNITY BASED MEDICAL SERVICES
ADULT AND EMANCIPATED MINOR
(PLEASE FILL OUT COMPLETELY)

Name: Last _____ **First** _____ **M.I.** _____ **Other Names Used**_____

Sex: M F Date of Birth _____ **Marital Status (Circle One) Single Married Divorced Widowed**

Tribe of Membership _____ **Tribal Number** _____ **Social Security Number** _____

Mother's Maiden Name _____ **Father's Name** _____

Home Phone: _____ **Alternate Phone:** _____

Current Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Medicaid/Soonercare #_____ **Medicare #** _____

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PRIVATE INSURANCE and POLICYHOLDER information (if Applicable):

Policy ID#_____ Policyholder name: _____

Address: _____State _____Zip_____ Policyholder Date of birth: _____/_____/_____

Group #_____ Effective/Beginning Date of Policy: _____

Name of Insurance Carrier: _____

Insurance Address: _____ Insurance Phone #_____

Employer Name and Address: _____

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Consent and Acknowledgement

I understand that the information given by me/or collected is necessary for the Cherokee Nation Health Services (CN Health) to provide for my health and wellbeing. I understand CN Health will seek payment from any medical program that I might be eligible to participate in or from any liable third party and I assign to CN Health all benefits for services rendered by CN Health. I understand that CN Health may verify the information necessary to process the claim.

I have been offered a copy of the CN Health Notice of Information Practices.

I give permission for CN Health to provide the following services to me: medical exams, laboratory studies, routine exams, fillings, preventive fluorides and emergency dental care, behavioral health services including evaluation and treatment, emergency health services including evaluation and treatment, and public health services.

The information given by me is true and correct to the best of my knowledge and belief.

_____

Patient Signature Date Time

_____

Witness Signature Date Time

Internal use only Community_____ CNH-PHN-07-DC (2/2017)

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to a component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

immunization action coalition
immunize.org

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4066.pdf • Item #P4066 (9/20)