Unity Healing Center Patient Registration Form

PATIENT INFORMATION:

Last Name:_____ First Name:_____ Middle Name:_____

Other Names (aliases):_____ Date of Birth:_____

Sex: ☐ Male ☐ Female Primary Language:_____

Religious Preference:_____ Ethnicity:_____

Race:_____ Place of Birth (City/State):_____

Indian Blood Quantum:_____

Tribe of Membership:_____ Enrollment Number:_____ Tribe Quantum:_____

Other Tribe of Membership:_____ Tribe Quantum:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone Number:_____ Other Number:_____

FAMILY INFORMATION:

Fathers Name:_____ Fathers Birthplace:_____

Fathers Employer:_____ Phone Number:

Mothers Maiden Name:_____ Mothers Birthplace:_____

Mothers Employer:_____ Phone Number:

EMERGENCY CONTACT:

Name:_____ Relationship to you:_____

Address:_____ Phone Number:

NEXT OF KIN:

Name:_____ Relationship to you:_____

Address:_____ Phone Number:

Do you have Medicaid/Medicare? Yes ☐No ☐

Effective Date:_____ Policy Number:_____

Please provide copy of card if applicable

Do you have any other Health Insurance? Yes ☐ No ☐ If yes, please complete below:

_____

Name of Insurance Policy Number Effective Date

_____

Name of Insurance Policy Number Effective Date

Program Use Only:

Patient Name: _____ DOB: _____ HRN: _____