

PATIENT REGISTRATION FORM

PATIENT INFORMATION:			
Last Name: _____	First Name: _____	Middle Name: _____	
Other Names (aliases): _____		Date of Birth: _____	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Language: _____		
Religious Preference: _____	Ethnicity: _____		
Race: _____	Place of Birth (City/State): _____		
Indian Blood Quantum: _____			
Tribe of Membership: _____		Enrollment Number: _____	
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/Medi-Cal? Yes <input type="checkbox"/> No <input type="checkbox"/>
Effective Date: _____ Policy Number: _____

Do you have any other Health Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete below:												
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 35%; border-bottom: 1px solid black;">Name of Insurance</td> <td style="width: 35%; border-bottom: 1px solid black;">Policy Number</td> <td style="width: 30%; border-bottom: 1px solid black;">Effective Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> <tr> <td style="border-bottom: 1px solid black;">Name of Insurance</td> <td style="border-bottom: 1px solid black;">Policy Number</td> <td style="border-bottom: 1px solid black;">Effective Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> </table>	Name of Insurance	Policy Number	Effective Date				Name of Insurance	Policy Number	Effective Date			
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<p style="text-align: center;"><i>Authorization to furnish information and assignment of benefits (Private Insurance, Medicare, Medicaid)</i></p> <p>I hereby assign to the Indian Health Service such benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me or dependents included in the insurance policy by I H S. I authorize payment of such benefits directly to I H S. I understand that this assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.</p> <p>Signature of Patient: _____ Date: _____</p>

<i>Desert Sage Youth Wellness Center, Hemet, CA</i>	<i>Patient Information</i>	
Program: Intake and Aftercare Services	First Name:	
Policy Reference: Pre-Admission Assessment – Intake Packet, c6.s2.0	Last Name:	
Form Number: DS-002 (Page 1 of 1)	Date of Birth:	
Form Date: 06/04/18	HRN:	