DESERT SAGE YOUTH WELLNESS CENTER
PATIENT REGISTRATION FORM

DESERT SAGE USE ONLY
Health Record Number: _____

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/**Medi-Cal?** Yes ☐ No ☐

Effective Date:_____ Policy Number:_____

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

_____

Name of Insurance Policy Number Effective Date

_____

Name of Insurance Policy Number Effective Date

Authorization to furnish information and assignment of benefits (Private Insurance, Medicare, Medicaid)

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.

Signature of Patient:_____ Date:_____