ANAV TRIBAL HEALTH CLINIC

QUARTZ VALLEY INDIAN RESERVATION

PATIENT REGISTRATION

_____ MEDICAL _____ BEHAVIORAL HEALTH _____DENTAL

PATIENT'S NAME: _____
LAST FIRST MIDDLE

SEX: ☐MALE ☐FEMALE DOB: _____ SS #: _____ MARITAL STATUS: _____

WHEN DID YOU MOVE TO THIS COMMUNITY: _____PLACE OF BIRTH: _____
CITY STATE

STREET ADDRESS: _____
CITY STATE ZIP

MAILING ADDRESS: _____
CITY STATE ZIP

TELEPHONE: (_____)_____(_____)_____(_____)_____
HOME WORK CELL /MESSAGE

EMPLOYER/ SCHOOL (IF A STUDENT) _____
INTERNET ACCESS: NO YES IF YES WHERE: HOME/WORK/SCHOOL/HEALTH CARE FACILITY/ LABRARY/ COMMUNITY CENTER

RACE/ETHNICITY [ ] AFRICAN AMERICAN [ ] ASIAN [ ] FILIPINO [ ] HISPANIC [ ] NATIVE AMERICAN/ALASKAN NATIVE

[ ] OTHER _____ [ ] PACIFIC ISLANDER [ ] WHITE RELIGIOUS PREFERENCE: _____

FINANCIAL RESPONSIBILITY ARE YOU A US VETERAN ☐NO ☐YES DOES THE PATIENT HAVE ANY OF THE FOLLOWING?

DENTAL INSURANCE: ☐NO ☐YES MEDICAL INSURANCE: ☐NO ☐YES MEDI-CAL: ☐NO ☐YES MEDICARE: ☐NO ☐YES

INSURED'S NAME: _____ RELATIONSHIP TO PATIENT: _____

SS # _____ DOB: _____ EMPLOYER: _____

INCOME INFORMATION: FAMILY SIZE: _____ MONTHLY INCOME: _____ ANNUAL INCOME: _____

FATHER'S FULL NAME: _____ DOB: _____ PLACE OF BIRTH: _____
CITY STATE

EMPLOYER: (If a minor) _____

MOTHER'S FULL MADIEN NAME: _____ DOB: _____ PLACE OF BIRTH: _____
CITY STATE

EMPLOYER: (If a minor) _____

EMERGENCY CONTACT (If a minor please list parent or guardian as the emergency contact)

NAME: _____ TELEPHONE #: _____

REALTIONSHIP: _____ STREET ADDRESS: _____
CITY STATE ZIP

NEXT OF KIN

NAME: _____TELEPHONE #: _____

REALTIONSHIP: _____ STREET ADDRESS: _____
CITY STATE ZIP

Release of Information/ Assignment of Benefits: ATHC has my permission to release information as needed for insurance processing and for my insurance to release payment to Anav Tribal Health Clinic. **I HEARBY AUTHORIZE TREATMENT**

Patient, Parent or Guardian: _____Printed Name: _____Date:_____

Present: ☐Proof of Identification ☐ Native Verification ☐ Insurance Card(s) INITIALS OF SCREENER: _____

HRN: _____

State of California-Health and Welfare Agency

CHILD HEALTH HISTORY

Department of Health Services

Name: _____ Birthdate: _____ Age:____ Sex:____
Address: _____
Directions to Location: _____ _____
Parents Name: Father: _____ Mother: _____
School: _____
Other persons living in home (name & age): _____

_____

Name of Child's Doctor: _____ Date of Last Visit: _____
Name of Child's Dentist: Date of Last Visit: _____
Do you have Medi-Cal: _____ Heath Insurance: _____
Other: _____
WHAT DO YOU WANT FROM US TODAY? _____

Yes	No	
_____	_____	Did your pregnancy last nine months?
_____	_____	Did you have problems during labor?
_____	_____	Was your delivery in a hospital?
_____	_____	Did you have a normal vaginal delivery?
_____	_____	Were there problems with you after the delivery?
_____	_____	Were there problems with the baby after the delivery?
		Baby's Birth Weight: _____ Length: _____ Head Circumference _____
		When did your child sit alone___ ___months walk alone _____ talk with distinct words_____
		Is your child breast fed_____ bottle fed _____ drinks from a cup _____
_____	_____	Is your child eating solid foods?
_____	_____	Is your child taking vitamins and/or iron?
_____	_____	Is your child taking fluoride?
_____	_____	Is your child taking any medicines?
		Explain: _____

_____

Yes	No	Has Your Child Ever Had:	Yes	No	
_____	_____	Measles (red or 10 day)	_____	_____	Ear Infections
_____	_____	German Measles (3 day)	_____	_____	Trouble with Hearing
_____	_____	Roseola (infant measles)	_____	_____	Frequent Colds (over 8/years)
_____	_____	Mumps	_____	_____	Bronchitis or Pneumonia
_____	_____	Whooping Cough	_____	_____	Allergy or Asthma
_____	_____	Chickenpox	_____	_____	Frequent Pain in Joints or Legs
_____	_____	Scarlet Fever or Strep Throat	_____	_____	Trouble with Seeing
_____	_____	Anemia	_____	_____	Trouble with Talking
_____	_____	Pain on Urination	_____	_____	Tuberculosis or Positive Skin Test
_____	_____	Constipation or Diarrhea	_____	_____	Heart Problem
_____	_____	Other Serious Illnessess or Hospitalizations (please list)			

YEAR	PROBLEM

Anav Tribal Health Clinic
Medical/Dental Department
Broken Appointment Policy/ Form

You are important to us, and we want to provide you with the best possible service. Our staff is working hard to provide quality medical/dental care to all our patients. Our appointment schedule is always filled far in advance. Broken appointments waste valuable time for other patients who are trying to get in for treatment.

To be able to best utilize the available time, we have the following policy.

Broken Appointment Policy:
Any patient who breaks two (2) appointments within a six-month period will be seen on an emergency basis only, as determined by the triage nurse/dental receptionist, for six months.

You will receive a broken appointment if:

1. You do not cancel your appointment with at least 24 hours' notice.
2. You do not appear for an appointment.
3. You are more than 10 minutes late for your appointment.

Confirming Appointment:
I hereby give my consent for the medical/dental staff to call and confirm my medical/dental appointment, by contacting me at my daytime phone number. If I do not wish to be contacted at this number, I will provide an alternate means of contacting me.

Day time phone #_____ Alternate #_____

I understand it is my responsibility to notify this office before my appointment time if I am unable to keep my appointment.

I have read and understand the broken appointment policy and confirmation consent.

_____ _____
Patient/Parent/Guardian Signature Date

Office Use only:

Provider	Broken Appointment Date	Staff Initials
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

Acknowledgement of Receipt of IHS/ATHC Notice of Privacy Practices

I hereby acknowledge receipt of Anav Tribal Health Clinic IHS/ATHC Notice of Privacy Practices At:

ANAV TRIBAL HEALTH CLINIC
9024 SNIKTAW LANE
FORT JONES, CA 96032

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Date
(State relationship to Patient) OR
Signature of Witness (if signature is a thumbprint of mark)

_____ _____
Signature and Title of ATHC Employee Date

For Patients Unable To Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the IHS/ATHC Notice of Practices because:

_____

_____

_____

_____ _____
Signature of ATHC Staff Date

Patient Responsibility

It is the patient's responsibility to wait in the clinic waiting area until called. While waiting, it's the patient's responsibility to be courteous, kind, considerate to other patients waiting to be seen.

It is the patient's responsibility to control their children and keep them quiet, and while parent or surrogate is being treated to seek care for the children prior to his/her visit. It is a parent's responsibility to understand that staff is unable to watch children during clinic hours.

It is the patient's responsibility to conduct themselves in an orderly manner, and to understand that voiced or physical hostility will not be tolerated under any circumstances.

It is the patient's responsibility to be respectful and considerate to all staff members.

It is the patient's responsibility to understand that disruptive behavior will be cause for refusal of services. Services may be continued at a later time, if proper behavior has been established.

I have read and understand the Patient's Responsibility and confirm Responsibility.

_____ _____

Patient's Signature Date

_____ _____

Parent/Guardian's Signature Date

_____ _____

Witness Signature Date

ANAV TRIBAL HEALTH CLINIC

Consent For Treatment:

I, (print name)_____ the undersigned, do hereby consent to routine medical/dental care and treatment for (patient name)
from the individuals who make up the health care team of the Anav Tribal Health Clinic.

Release of Information:

It is understood that the information in my health record will be made available in the clinic; pertinent information from my health record may be shared with the other health care provider(s) to whom I am referred.

"Special patient permission" is needed to release this information if the patient is treated for alcohol or drug abuse.

Assignment of Benefits:

For the purpose of insurance/payment reimbursement, the undersigned agrees that to the extent necessary to determine liability for payment and to obtain the reimbursement, the Anav Tribal Health Clinic may disclose portions of the patient's record. In addition disclosure of his/her record may be made to any individual of corporation, which is or who may be liable for all or any portion of the Anav Tribal Health Clinic's charges. This includes, but is not limited to insurance companies, health care service plans, or worker's compensation carriers.

The undersigned also assigns any health care benefits the Anav Tribal Health Clinic and authorizes health care benefits to be paid directly to the Anav Tribal Health Clinic.

_____ _____
Patient's Signature Date

_____ _____
Parent/Guardian's Signature Date

_____ _____
Witness' Signature Date