BILLINGS URBAN INDIAN
HEALTH & WELLNESS CENTER

NEW PATIENT REGISTRATION PACKET

Today's Date: _____ DOB: _____ Social Security #: _____

Last Name: _____ First Name: _____ Primary Language: _____

Secondary Language: _____

Biological Sex: ☐ Female ☐ Male

Describe your Gender:
☐ Female
☐ Male
☐ Transgender Female
☐ Transgender Male
☐ Non-Binary
☐ Agender
A gender not listed: _____

Ethnicity: ☐ American Indian or Alaska Native
Tribal Affiliation(s): _____
☐ Black or African American
☐ Middle Eastern or North African
☐ Hispanic or Latinx
☐ Native Hawaiian or Pacific Islander
☐ Caucasian
☐ Asian
Other : _____

Contact Information

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Street Address (if different from mailing address): _____

Primary Phone #: _____
◯ (Extended) OK to leave message with detailed information
◯ (Brief) Leave message with call-back number only

Secondary Phone #: _____
◯ (Extended) OK to leave message with detailed information
◯ (Brief) Leave message with call-back number only

Alternate Phone #: _____
◯ (Extended) OK to leave message with detailed information
◯ (Brief) Leave message with call-back number only

Email Address: _____

Emergency Contact Information

Contact Name: _____ Relationship: _____

Contact Phone #: _____ Secondary Phone #: _____

Preferred Pharmacy

Pharmacy Name: _____ Pharmacy Phone #: _____

Authorization and Consent to View RX History from External Source:

I authorize Billings Urban Indian Health and Wellness Center to view all available RX History from an external source. I am aware that Billings Urban Indian Health and Wellness Center uses a secure connection to send and receive prescriptions.

_____ _____ _____

Signature of Patient, or Patient Representative | Date | Relationship to Patient if not signed by Patient

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Insurance Information

Primary Insurance:_____ Secondary Insurance:_____

Cardholder Name: _____ DOB:_____ SSN#:_____

PATIENT HAS PROVIDED BUIHWC WITH A COPY OF MOST CURRENT AND ACCURATE INSURANCE CARDS

Acknowledged Receipt of HIPPA Notice

Billings Urban Indian Health and Wellness Center (BUIHWC) is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the HIPAA Notice of Privacy Practices and Patient Bill of Rights.

_____ _____
Signature of Patient or Legal Guardian Date

In accordance with the HIPAA guidelines, Billings Urban Indian Health and Wellness Center is authorized to discuss my medical information with the following individuals.

HIPAA Authorized Person's Name	Relationship to Patient	Phone Number

Do you utilize a transportation service? ○ Yes ○ No

If yes, may BUIHWC give information in regards to dates and times of appointments to service? ○ Yes ○ No

Do you have a medical Power of Attorney? ○ Yes ○ No If so, please provide a copy for our records.

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Authorization to Treat

I, the undersigned patient, hereby authorize Billings Urban Indian Health and Wellness Center and its staff to administer such treatment as is necessary, and to perform services and /or procedures as are considered necessary on the basis of the findings during the course of delivery of health care services and treatment.

I have read and fully understand the above Authorization to Treat, the reasons why the treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative methods of treatment which have been explained to me. I also certify that no guarantee or assurance has been made as to the results that may be obtained by services received at Billings Urban Indian Health and Wellness Center.

Print Name: _____

Patient Signature: _____ _____
Date

Witness: _____ _____
Date