Billings Urban Indian Health and Wellness Center
PATIENT REGISTRATION FORM

RPMS #

Patient's Legal Name _____
Last *First* *Full middle name*

Sex M / F Social Security Number_____ Marital Status _____

Address _____ _____ _____ _____
City *State* *Zip*

Date of Birth _____ City & State of birth _____ When did you move here? _____

Phone ( ) _____ ( ) _____ ( ) _____
Home *Work* *Cell/Message*

Employer_____

Fathers Name _____ Mother's Maiden Name _____
Last *First* *Last* *First*

IF PATIENT IS UNDER AGE 18

Guardian: _____ *Relationship to Patient:* _____

Address if different _____

City *State* *Zip*
Telephone: ( ) _____ ( ) _____ ( ) _____
Home *Work* *Cell/Message*

*Father's Employer*_____ *Mother's Employer* _____

E-MAIL Address _____ @ _____
We may use your Email address to send you announcements of events you may have an interest in or when attempts to reach you by phone or postal mail have failed.

If you are a member of a Native American or Alaska Native Tribe, please provide the name of the tribe and a copy of your membership documentation. **Tribe** _____

Emergency Contact
Name _____ Phone _____
Complete
Address _____ Relationship to patient _____

Next of Kin
Name _____ Phone _____
Complete
Address _____ Relationship to patient _____

Date Entered in RPMS
_____

RPMS #

As a Federally Qualified Health Center and to keep our services affordable, we receive grant funding. To qualify for these resources we must collect the following information on all our clients. Please support us by answering all these questions.

Financial Responsibility

Do you have Health Insurance? (Please circle) Yes / No

Medical_____Dental_____Vision_____ OR Medicare_____ Medicaid _____

If you are a dependent on someone else's insurance we will need the following to verify eligibility and to bill the insurance

_____ _____ _____

Insurance Card Holders Full Name Date of Birth Sex

Be sure to provide the card(s) so we may make a photocopy.

>Are you a US Veteran? Yes / No >Do you have VA benefits? Yes / No - Branch _____ Discharge Date _____

>Do you have an Advance Directive? Yes / No - If YES, is it in the form of a "**Living Will**" or "**Power of Attorney**"?
(Please circle)

Indicate your ethnicity

[ ] Not Hispanic or Latino [ ] Hispanic or Latino [ ] Unknown

Indicate your race(s)

[ ] American Indian/Alaska Native [ ] Asian [ ] Black or African American

[ ] Hispanic or Latino [ ] Filipino [ ] Native Hawaiian or Pacific Islander

[ ] White [ ] Other _____

What is your primary language (the language you speak at home)? _____

What other languages do you speak/preferred language? _____

Do you need an interpreter? _____ What is your religious preference? _____

What is your highest level of education? _____

Are you a migrant agricultural worker? Yes / No Are you a seasonal agricultural worker? Yes / No

Are you current homeless? Yes / No

If yes, please indicate if you are staying in a shelter? _____ In a transitional living arrangement? _____

Doubling Up? _____ Living on the street? ____

Do you have access to the Internet? YES / NO *Where:* Home / Work / School / Clinic / Library / Community Center

Income Information

Number in Family _____Monthly Income $_____ or Annual Income $_____

Release of Information / Assignment of Benefits: ***Billing Urban Indian Health and Wellness Center*** has my permission to release information as needed for insurance processing and for my insurance to release payment to ***Billings Urban Indian Health and Wellness Center***.

I HEARBY AUTHORIZE TREATMENT

Signature of PATIENT OR GUARDIAN

Printed Name & Date

_____ _____

Present: Photo ID, Native Documentation, & Insurance Card(s)

Date Entered in RPMS

_____