Fond du Lac Human Services Division

Registration Form

For Office Use Only

Chart #_____

Patient Information – Policy requires us to complete a new form annually, Miigwech.

Name: _____ Other Name(s): _____

Last First Middle (Maiden)

Date of Birth: _____/_____/_____ Social Security Number: _____

Gender: ☐ Female ☐ Male ☐ Other Are you a Veteran? ☐ Yes ☐ No

Ethnicity: Hispanic or Latino ☐Yes ☐No

Race: (check all that may apply)

☐ American Indian/Alaska Native; ☐ African American; ☐ Caucasian; ☐ Asian; ☐ Native Hawaiian or Other Pacific Islander;

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: _____ Apt.: _____

City: _____ County: _____ State: _____ Zip: _____

Primary Contact Number: _____ Work Phone: _____

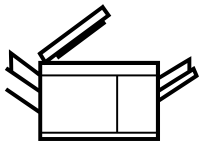
Cellular Phone Number: _____ Email: _____

Birth Mothers Name: _____

First Middle Last Maiden

What "Community" do you affiliate with? _____

Insurance & Employment Information:



Please give your insurance card to the registration staff at the desk.
We need to make a copy. If you do not have insurance, we may refer you to our patient advocates to discuss insurance coverage options.

Employment Information ☐ Full time ☐ Part time

Employer Name: _____ Phone #: _____

Employer Address: _____ State: _____ Zip: _____

Occupation: _____

Full-time Student: ☐ No ☐ Yes If yes, are you covered by a parent's Health Insurance? _____

Primary Insurance:

Name of Insurance: _____ Effective Date: _____

Name of Policyholder: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Tribal Enrollment Information

American Indian/Alaskan Native: ☐ Yes (Enrollment Number Required) ☐ No

Name of Tribe Enrolled: _____ Enrollment Number: _____

Descendant of American Indian/Alaskan Native: ☐ Yes ☐ No

☐ Parent (Requires courthouse birth certificate of patient with enrollee listed as parent)

☐ Grandparent (Requires patient AND parent's courthouse birth certificates linking the enrollee)

Name of Enrollee: _____Enrollment Number: _____

Name of Tribe Enrolled in: _____

Non-Indian but meets one of the following requirements to be eligible to receive services:

☐Has Fond du Lac Employee Insurance. (need copy of card) complete⇨	Policy holder Name Policy holder ID: Effective Date:
☐Pregnant with an Indian Child. complete⇨ (Statement of Paternity required)	Father of Child: Date of Birth: Enrollment Number:
☐ Lives with a tribal member and is being seen for a contagious illness or depression. complete⇨ (Proof of Indian Household form required)	Tribal Member's Name: Date of Birth: Enrollment Number:

Emergency Information

Emergency Contact: _____ Relationship: _____

Address: _____ Phone Number: _____

City: _____ County: _____ State: _____ Zip: _____

Relation: (please check one) ☐ Caregiver ☐ Emergency Contact ☐ Next of Kin

Responsible Party/Guarantor (a person that agrees to be responsible for another's debt; the person who pays the patient's bills)

☐ Self

Name: _____

Address: _____

Phone Number: _____

PRIVACY RIGHTS (Please initial **ALL** boxes):

Initial

PRIVACY ACT OF 1974, P.L. 93-579. I understand that the information given by me and/or collected is necessary for the Fond du Lac Human Services staff or IHS contractors to provide services for my health and well being. Furthermore, I have been informed that my health record or any portion of the record shall not be disclosed to another agency or person without my signed consent. I certify that the information given is true and correct.

Initial

HIPAA – I have been provided an opportunity to review Fond du Lac Human Services Division Notice of Privacy Practices (brochure available at registration desk). I understand that I can get an electronic copy of the Notice of Privacy Practices at http://www.fdlrez.com/humanservices/.

Initial

Patient Centerned Medical Home (PCMH) – Fond du Lac Human Services Division is an accredited PCMH. The foundation of a PCMH is the relationship between the patient, his/her family, and the PCMH. All of Fond du Lac Human Services Division departments are considered to be a part of the PCMH; this approach applies highly functioning teams who are able to coordinate comprehensive holistic care that meet the need of every patient. Care coordination will ensure all elements of care are organized across the broader healthcare system, both internally and externally.
I have been provided an opportunity to review Fond du Lac Human Services Division Patient Centered Medical Home brochure (available at registration desk). I understand that I can get an electronic copy of the Patient Centered Medical Home brochure at http://www.fdlrez.com/humanservices/.

Initial

Communications – Fond du Lac Human Services Division, or affiliates, may communicate via phone, email, text message or voicemail regarding services such as appointment reminders or patient satisfaction surveys. I authorize Fond du Lac Human Services Division, or affiliates, to call me, send an email, and/or, text messages for appointment reminders, or patient satisfaction surveys to the phone number or email address provided, including leaving messages on voicemail.

Your Communications Options- At Fond du Lac Human Services Division your health care is important to us. Our goal is to provide you with relevant and useful information pertaining to your health care. If you wish to opt out of patient satisfaction surveys please check the appropriate box below.

☐ I do not want to participate in patient satisfaction surveys

Right to Revoke:
I understand that I have the right to revoke this authorization at any time by writing to Fond du Lac Human Services, 927 Trettel Lane, Cloquet, MN; if the consent is revoked, it will not change disclosures that have already been made prior to the date of revocation.

Consent Expiration:
This consent will expire one (1) year from the date of the signature below.

Signature: _____ Date: _____

Relationship to Patient: _____ (if patient, leave blank)

Signature of Staff Person accepting information: _____