PONCA TRIBE OF NEBRASKA

REGISTRATION FORM

(Please Print)

Today's date:				HRN#:	
PATIENT INFORMATION					
Patient's last name: First: Middle:			Sex: ❑ M ❑ F	Birth date: / /	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name?	If not, what is your legal name?	(Former name):			
❑ Yes ❑ No					
Street address:		Social Security no.:		Home phone #:	
				Message phone #:	
P.O. Box:	City:		State:	ZIP Code:	
Place of Birth (City, State):		Current Community:		Since:	

RELIGION/TRIBAL DATA/EMPLOYMENT			
Religious Preference:		Classification/Beneficiary: ❑ Indian/Alaska Native ❑ Other:_____	
Tribe of Membership:		Enrollment #:	Tribe Quantum:
Indian Blood Quantum:	❑ Full ❑ Half ❑ One-Fourth (1/4) ❑ Other: _____		
If you are less than 4/4(full) of the above tribe, what other tribe are you?			Tribe Quantum:
Father's Name:		Email address:	Phone #:
City/State of Birth		Tribe:	Alt. Phone #:
Mother's Maiden Name:		Email address:	Phone #:
City/State of Birth		Tribe	Alt. Phone #:
Employer Name:		Phone #:	❑ Full Time ❑ Part Time
Address/City/Zip:			
Spouse's Employer Name:		Phone #:	❑ Full Time ❑ Part Time
Address/City/Zip:			
Total # people in household:		Total Household Income:	

NAME	RELATIONSHIP	SOCIAL SECURITY #	DATE OF BIRTH

EMERGENCY CONTACT/NEXT OF KIN

EC-Name:	Address/City/Zip:	Phone #:
Relationship:		
NOK-Name:	Address/City/Zip:	Phone #:
Relationship:		

INSURANCE INFORMATION

****Please give ALL your insurance card(s) to staff or provide a copy of the front and back of the card(s) if mailing****

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance *(Check all that apply)*	❑ Private Insurance: _____ (Please List Name) I.D.: _____ Effective Date:_____/_____/_____ ❑ Medical (Family/Self) ❑ Dental (Family/Self) ❑ Vision (Family/Self) ❑ Medicare: I.D. # _____ Part A Effective Date:_____/_____/_____ Part B Effective Date:_____/_____/_____ Part D Effective Date:_____/_____/_____ ❑ Medicaid I.D. # _____ Effective Date:_____/_____/_____

Are you a Veteran: ❑ Yes ❑ No	If yes, what is your serial number:	Which Branch did you serve in:	
Entry date:	Discharge date:	Group no.:	Policy no.:
Vietnam connected: ❑ Yes ❑ No		Service Connected: ❑ Yes ❑ No	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

PATIENT SIGNATURE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize Ponca Tribe of Nebraska/Fred LeRoy Health & Wellness Center/Ponca Hills Health & Wellness Center or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how we may use and disclose health care information about you. As provided in our notice, the terms of our notice may change. If we change our terms you may obtain a revised copy.

I, _____ (please print patient name) have received a copy of the Ponca Tribe of Nebraska's Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.

PATIENT SIGNATURE: _____ DATE: _____

AUTHORIZED
REPRESENTATIVE: _____

RELATIONSHIP TO
PATIENT: _____

_____ _____
Witness Location Privacy Notice Written Acknowledgement was obtained

DOCUMENTATION OF GOOD FAITH EFFORT

_____ Attempt to distribute the Notice of Privacy Practices to the Patient/Parent/Legal Guardian but the Patient/Parent/Legal Guardian declined to acknowledge the receipt of the Notice of Privacy Practices

_____ Patient/Parent/Legal Guardian stated that they had already received the Privacy Notice

_____ The Notice of Privacy Practices was mailed to the Patient/Parent/Legal Guardian at the last known address of the patient

_____ Other

_____ _____
Witness Date