Little Traverse Bay Bands Health Clinic Chart #:_____

PATIENT REGISTRATION

In order for the Little Traverse Bay Bands to continue providing efficient health services to you and your family, we must register you with LTBB. This information assists the Physicians and other health care providers decide the best course of healthcare. Thank you for your cooperation.

Note: If you have your Tribal ID, Driver License/State ID, Second Proof of residency, and/or Health Insurance card, please leave a copy with the receptionist.

PATIENT NAME **PROVIDE INFORMATION FOR THE PATIENT THAT WILL BE SEEN**

_____ _____ _____ _____ _____

FIRST **MIDDLE** **LAST** **DATE OF BIRTH** **SOCIAL SECURITY #**

MARITAL STATUS M / S / D / W **SEX** M_____ F_____

CITY OF BIRTH:_____ **STATE:**_____ **OTHER NAMES USED:**_____

CURRENT COMMUNITY:_____ **LOCATION OF HOME:**_____

DATE YOU MOVED TO THIS CURRENT COMMUNITY_____

MAILING ADDRESS:_____

ADDRESS (PLEASE INCLUDE STREET IF PO BOX) CITY STATE ZIP

HOME/MESSAGE PHONE:_____ **WORK PHONE:**_____

RELIGIOUS PREFENCES:_____ **TRIBE NAME:**_____

INDIAN BLOOD QUANTUM (FULL,HALF,1/4,ETC.):_____ **ENROLLMENT NUMBER:**_____

ARE YOU REGISTERED WITH ANY OTHER FEDERALLY RECOGNIZED TRIBE?_____

IF SO, WHICH TRIBE?_____ **DEGREE?**_____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name:_____ **Phone:**_____ **Relationship:**_____

Address: _____

NEXT OF KIN: This is the person who would give consent for treatment, a person that you trust to sign documents for you if for a reason you are not able to do it yourself.

Name: _____ **Phone:** _____ **Relationship:** _____

Address: _____

PARENT INFORMATION (Please indicate if the parent is deceased):

FATHER'S NAME: _____ **CITY & STATE OF BIRTH:** _____

MOTHER'S NAME:_____ **CITY & STATE OF BIRTH:**_____

SEE REVERSE FOR ADDITIONAL QUESTIONS

BILLING INFORMATION

This information is necessary for billing your Health Insurance.

ARE YOU COVERED BY: **MEDICARE** **YES ( ) NO ( ) If yes ID#:**_____
MEDICAID **YES ( ) NO ( ) If yes ID#:**_____
Other Insurance **YES ( ) NO ( ) If yes ID#:**_____

NAME OF COMPANY:_____ **Effective Date:**_____
PRIMARY CARRIER:_____ **GROUP #:**_____
PRIMARY CARRIER DATE OF BIRTH:_____

EMPLOYMENT INFORMATION

Patient's employer or parent(s) employer if patient is a minor.

BUSINESS NAME:_____ **Part-time/Full-time:**_____

ADDRESS:_____ **PHONE:**_____

***SPOUSE EMPLOYMENT*:**
BUSINESS NAME:_____ **Part-time/Full-time:**_____

ADDRESS:_____ **PHONE:**_____

IF YOU ARE SELF-EMPLOYED,WHAT TYPE OF WORK DO YOU DO?_____

MILITARY INFORMATION

Are you a VETERAN? **YES ( ) NO ( )** If yes, what was your serial number?_____
Which Branch did you serve in?_____
Entry Date:_____ Discharge Date:_____
Vietnam Connected YES ( ) NO ( ) Service Connected YES ( ) NO ( )

CONSENT TO TREATMENT

I hereby grant authority to the Little Traverse Bay Bands Health Department provider in charge of the patient, whose name appears below; to administer any treatment or to administer any such local anesthetic agents and to perform such treatments as may be deemed necessary or advisable in the diagnosis and treatment of this patient. The Little Traverse Bay Bands Health Department may release any information from computer services for maintenance of health statistics to Indian Health Service and to insurance carriers to assist in the processing of health insurance claims.

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

PATIENT or GUARDIAN SIGNATURE:_____ **DATE:**_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:

I have been presented with a copy of Little Traverse Bay Bands (LTBB) Health Department's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

PATIENT or GUARDIAN SIGNATURE:_____ **DATE:**_____
DATE RECEIVED:_____ **Initials:**_____