# New Patient Registration
# Special Circumstances Registration
CONFIDENTIAL INFORMATION

**Welcome to the Nisqually Health Center! Please fill out this form completely. If you have any questions or concerns, please do not hesitate to ask for assistance, we will be happy to help!**

**PATIENT INFORMATION:**
SSN:_____
Patient Name (First, MI, Last): _____
Sex: ☐Male ☐Female
Tribe:_____, or Non -Tribal_____
Date of Birth: _____
Marital Status (circle one): ☐Married ☐Single ☐Widowed ☐Divorced

Mailing Address: _____ City: _____ State: ____ Zip: _____
Street Address (if different): _____
Email Address: _____
Phone #: _____Cell #: _____ Work #: _____ Ext. ____

**Place of Employment** (check one):
Nisqually Tribe___, Nisqually Red Wind Casino__ Nisqually Markets, NWIF___,Wa-He-Lute __

**Eligibility Category**: Name of the Nisqually Community household, or Employee Household:
_____

**PRIMARY INSURANCE INFORMATION:**
Insurance Company Name: _____
Address: _____
Policy#_____ Group#:_____
What does the plan cover? (Circle all that apply): Medical/Dental/Vision/Rx/Mental Health
Policy Holder's Name: _____
Policy Holder Phone #: _____
Relationship to Patient: _____
Policy Holder's DOB: _____

**Whom can we contact in case of an emergency?**
Name: _____
Relationship: _____Address: _____
Phone: _____

***AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS***

*POLICY HOLDER'S NAME:* _____

*D.O.B:*_____ *SS#*_____

*CURRENT ADDRESS:*_____

*The Nisqually Tribal Health Department may disclose all or any part of the patient's record to any person or third party supplementary plan, which is or may be liable under a contract with the Clinic, the Patient, a family member and /or employer of the patient for all or part of the Clinics charge. Including, but not limited to Insurance companies, workman's comp./other etc.,* ***Medicare*** *and Medicaid.*

*I hear by assign, transfer and set over to Nisqually Tribal Health Department all my right, title and interest to my medical reimbursement benefits under my Medicare or Insurance coverage, as well as any other third party liability reimbursements.*

*******I authorize the release of any information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. *******

***THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. IF ANY OF THIS INFORMATION CHANGES, I WILL BRING IN THE CORRECT INFORMATION.***

_____ _____

***Signature of Patient*** ***Date***