

Eligibility Status: [] Prenatal Only [] Direct [] Contract [] Denied [] Emergency Only [] Pending

Tulalip Health System

Patient Registration

SECTION A PATIENT DEMOGRAP Patient Name: [LAST]	HIC INFORMATION [FIRST]		1]		atient Sex			
Other Names Used:	Date of Birth		Place of Birth			[]M/ Social Secu		
	Date of Dirth	•					, , , , , , , , , , , , , , , , , , ,	
Address:	City:			State:	Zip Code		County:	
How long at current address?					Is this on a Reservation? Marital Status:			
Home Phone#: ()	Cell #: (Cell #: ()			[]Yes []No []Single []Married []Widow []Divorced			
Primary #? []Yes []No	Primary #?	× ,			If yes, which Reservation? []Significant Other			
SECTION B PATIENT TRIBAL INFO Are you: [] Enrolled Tribal Member [] Enrollment is Pending [] Descendent of an Enrolled M [] Prenatal Only- Paternity Affic [] Non-Native living in Tribal Hou [] Non-Native	ember avit on File		Tribe Name Enrollment Blood Quan	# (if applica	ble):			
Mother's Maiden Name: [Last]	[First]		[Middle Initial] Cell # ()				
Mother's Email Address:				Alternate # ()				
Father's Name: [Last]	[First]		[Middle Initial	al] Cell # ()				
Father's Email Address:				Alternate	# ()		
SECTION C EMPLOYMENT Are you employed: [] Yes [] No	T INFORMATION	o, how long	g?	0	ccupation:			
Employer Name: How long			employer?	W	Work Phone#			
Address:	City:		Sta	ate:	z: Zip Code:			
SECTION D OTHER PATIENT INFO Ethnicity: [] Not Hispanic or Latino		Unknown	by Patient	[] Declined	to Answe	r		
Race: [] American Indian/Alaskan [] Native Hawaiian or other		African Ar Unknown	merican [] by Patient	White				
Primary Language:	[]English []Spanish	n []Oth	er:					
Are you a migrant worker? [] Yes] No	Are	you homeles	ss? []Y∉	es []No	Where?		
Does the patient have internet access? Where?	[]Yes []No		ients ail Address:					
[]Home []Work []School []F []Library []Tribe/Community Cente	[] Mobile Device		[]Home [] []Library []					
Do we have permission to send generic	health information to y	our email	address?	[]	Yes []	No		
What is your preferred method to receive r	eminders?			[]	Phone [] Mail []	Email	
SECTION E MILITARY SERVICE Were you ever in any Military Service?		1 1		I No			ch Branch?	
were you ever in any minitary Service?		ין]		No		If YES, whi		
Revised 9/2018						Page 1 of 2	(Turn Over)	



Eligibility Status: [] Prenatal Only [] Direct [] Contract [] Denied [] Emergency Only [] Pending

Person who can be contacted in the event of an emergency: Relationship: Phone# Name: City: State: Zip Code: Name: Relationship: Phone# Name: Relationship: Phone# Address: City: State: Zip Code: Section 6: ALTERNATE RESOURCEINFORMATION Medicare Number: Zip Code: Section 6: ALTERNATE RESOURCEINFORMATION Medicare Number: Zip Code: Washington State MEDICAD Program Medicare Number: Zip Code: Zip Code: Private Instrument evention in WA State Medicaid Program? []Yes []No Policy Number Group Number Plan Name: Private Instrument Parls (zip Code) Policy Number Group Number State: Zip Code: State: State: <th colspan="9">SECTION F CONTACT INFORMATION</th>	SECTION F CONTACT INFORMATION								
Next of Kin (if different from your Emergency Contact above) Phone# Name: Relationship: Phone# Address: City: State: Zip Code: Section (c) AttresnAtt ReSOURCE INFORMATION Medicare Number: Zip Code: Webington State MEDICAD Program If Yes: INO Medicare Number: Private Insurance Plan? [Yes: [No File Social Security Number Private Insurance Plan? [Yes: [No Private Insurance Plan? Date of Birth: Section H Private Insurance Plan? [Yes: [No Private Insurance Plan? Date of Birth: Section H Private Insurance Plan? [Yes: [No Private Insurance Plan? Date of Birth: Section H Private Insurance Plan? [Yes: [No Private Insurance Plan? Date of Birth: Section H Private Insurance Plan? [Yes: [No Private Insurance Plan? Date of Birth: Section H Private Insurance Plan? [Yes: [No Private Insurance Plan? Date of Birth: Section H Private Insurance Plan? [No Insurance Plan Insurance<):	Phone#					
Name: Relationship: Phone# Address: City: State: Zip. Code: SECTION C ALTERNATE RESOURCE INFORMATION Medicare Number: Zip. Code: Section C ALTERNATE RESOURCE INFORMATION Medicare Number: Zip. Code: Washington State MEDICADP Program Are you currently have Medicaid Program? [Yes []No Fig. [No Private Insurance Print Partice Information Private Insurance Print Insurance Print Information Date of Birth: Date of Birth: SECTION H Privace Notice and Other Information Privace Notice Date of Birth: SECTION H Privace Notice and Other Information: Their Social Security Number: Date of Birth: SECTION H Privace Notice Privace Notice Privace Notice Privace Notice Health Insurance Portability and Accountability Act (HIPAA) of April 14, 2003 Privace Notice Privace Notice Privace Notice • Provide (Medicare business) Provide Insurance or support by contractual agreement Privace Notice Privace Notice • Proble healthflaw required agreement Privace Notice Privace Notice Privace Notice of Privace Praci	Address:	City:		State:	Zip Code:				
Address: City: State: Zip Code: SECTON 6 ALTERNATE RESOURCE INFORMATION Medicare Number: [] Yes [] No Mashington State MEDICAD Program Are you currently have Medicare Number: [] Yes [] No [] Yes [] No Washington State MEDICAD Program Are you currently encolled in WA State Medicaid Program? [] Yes [] No [] Yes [] No Private INSURANCE Private INSURANCE [] Yes [] No Policy Number Group Number Plan Name: [] Yes [] No Policy Number Group Number Plan Name: [] Yes [] No Policy Number: Date of Birth: SECION H Privacy Notice and Other Information Health Insurance Portability and Accountability Act (HIPAA) of April 14, 2003 Privacy Notice Internation: Internation: Internation: • Poptiment Coperation (halthour point/search samesia) Accountability and Accountability and Accountability and Accountability action is not: granted we are required to give you a written response Internation: • Postimentify to request a restriction of disclosure of above. Requests must be submitted in writing for trovice. Internatin transin: • Postime Taiphone a									
SECTION G ALTERNATE RESOURCE INFORMATION MEDICARE PROGRAM []Yes []No Do you currently haw Medicaid Carse? []No Mashington State MEDICAD Program Are you currently enrolled in WA State Medicaid Program? []Yes []No Private Insurance Plan? []Yes []Yes []No Private Insurance Plan? []Yes []Yes Date of Birth: SECTION IN Privacy Notice and Other Information Privacy Notice and Other Information Date of Birth: SECTION IN Privacy Notice and Other Information Privacy Notice Date of Birth: SECTION IN Privacy Notice and Other Information Privacy Notice Date of Birth: SECTION IN Privacy Notice and Other Information: Trainterimet Privacy Notice How well use of diables your private health information: Trainterimet Privacy Notice How well use of diables your private health information: Trainterimet Privacy Notice How well use of diables your private health information: Trainterimet Privacy Notice Privacy Notice Privacy Notice Privacy Notice Privacy Notice Use of Birth: Openiation floating thealth and business) Date Date	Name:	Relationship):		Phone#				
MEDICARE PROGRAM []Yes []No Do you currently have Medicare? []No Medicare Number: Washington State MEDICAID Program Are you currently enrolled in NVA State Medicaid Program? []Yes []No Hyse, please give Medicaid Number: Private Insurance Plan? []Yes []No Private Insurance Plan? []Yes []No Policy Number Plan Name: Private Insurance Optoblity Astate Medicaid Program? Who is the primary insured (policy holder)? Their Social Security Number: Date of Birth: SECTION H Privacy Natice and Charl Information Health Insurance Portability and Accountability Act (HIPAA) of April 14, 2003 Privacy Notice Yow we will use or diacises you private health information: • • Payment • Operations (healthare business) • Apprint • Operations (healthare business) • Apprintents/emrindem • Payment • Operations (healthare business) • Apprintents/emrindem • Public Hardhare business • Apprintents/emrindem • Public Hardhare business • Public Information is not granted we are required to give you a written response • Have been offered and or received a copy of the Tulaip Health System Notice of Privacy Practices.		•		State:	Zip Code:				
Do you currently have Medicate? Medicare Number: []Yes []No Washington State MEDICAID Program Are you currently enrolled in WA State Medicaid Program? []Yes Are you currently enrolled in WA State Medicaid Program? []Yes []No Private INSURANCE []Yes []No Private Insurance Plan? []Yes []No Private Notice and Other Information Date of Birth: SECTION H Privately Notice and Other Information Health Insurance Portability and Accountability Act (HIPAA) of April 14, 2003 Privacy Notice Private Notice Private Notice Private Notice In Trainment - Operatione Privacy Notice Paymenti Obsenitioner to an operative solutions in and submitted in writing for review. If reatriction is not granted we are required to give you a written response In have: Payment Date Public health/taw required Vau how the high for review. If reatriction is not granted we are required to give you a written response In have privacy Notice of Privacy Prac		N							
Are you currently enrolled in WA State Medicaid Program? [] Yes [] No If yes, please give Medicaid Number: Private Insurance Plan? [] Yes [] No Private Insurance Plan? [] Yes [] No Policy Number Group Number Plan Name: Private Insurance Plan? [] Yes [] No Policy Number Group Number Plan Name: Private Insurance Portability and Accountability Act (HIPAA) of April 14, 2003 Private Notice Pate of Birth: SECTION H Private Insurance Portability and Accountability Act (HIPAA) of April 14, 2003 Private Notice Private Insurance Portability and Accountability Act (HIPAA) of April 14, 2003 Private Notice • Pogenetics developed and Chece and Other Information: • Pogenetics • Pogenetics •	Do you currently have Medicare?		Medicare Number:						
If yes, please give Medicaid Number: PRIVATE INSURANCE Privat Insurance Plan? Yes Name: Privat Insurance Plan? Yes Name: Date of Birth: Who is the primary insured (policy holder)? Their Social Security Number: Date of Birth: SECTION H Privacy Notice and Other Information Privacy Notice How will use of disclose your private health information: • Privacy Notice How will use of disclose your private health information: • Privacy Notice How will use of disclose your private health information: • Payment • • Operations (healthcare business) • • Appointments/reminiders • • Public healthlwair required You have the right to request a restriction of disclosure of above. Requestment writing to review. If restriction is not granted we are required to give you a written response I have been offered and or received a copy of the Tulalip Health System Notice of Privacy Practices. • It pay internitive Patient Initials • Date • Acknowledge Receipt of Notice of Privacy Practices • Date • • I patient/Parent or Guardian Signature Date Date • •									
Private Insurance Plan? []Yes []No Policy Number Group Number Plan Name: Their Social Security Number: Date of Birth: SECTION H Privacy Notice and Other Information Health Insurance Portability and Accountability Act (HIPAA) of April 14, 2003 Privacy Notice How we will use or disclose your private health information: • • Treatment • • Operations (healthcare business) • • Operations (healthcare business) • • Payment • Operations (healthcare business) • Appointmentstreminders • Business associates who provide services or support by contractual agreement • Public healthbar equiled You have the right to request a restriction of disclosure of above. Requests must be submitted in writing for review. If restriction is not granted we are required to give you a written response I have been offered and or received a copy of the Tulalip Health System Notice of Privacy Practices. https://www.tulaliphealthsystem.com/PrivacyPolicy []	If yes, please give Medicaid Number:		[]Yes []No					
Plan Name:									
Who is the primary insured (policy holder)? Their Social Security Number: Date of Birth: SECTION H Privacy Notice and Other Information Health Insurance Portability and Accountability Act (HIPAA) of April 14, 2003 Privacy Notice - Health Insurance Portability and Accountability Act (HIPAA) of April 14, 2003 Privacy Notice - Payment - • Operations (healthCare business) • Operations (healthCare business) • Appointments/reminders • Business associates who provide services or support by contractual agreement • Public healthAw required You have the right to request a restriction of disclosure of above. Requests must be submitted in writing for review. If restriction is not: granted we are required to give you a written response I have been offered and or received a copy of the Tulalip Health System Notice of Privacy Practices. https://www.tulaliphealthsystem.com/PrivacyPolicy [] Patient Initials Acknowledge Receipt of Notice of Privacy Practices Date [] Patient/Parent or Guardian Signature Date [] For Patients Unable to Acknowledge Receipt, I hereby certify that the patient was unable to acknowledge receipt of the No			Policy Number		Group Number				
Health Insurance Portability and Accountability Act (HIPAA) of April 14, 2003 Privacy Notice Prove will use or disclose your private health information: Prove will use or disclose your private health information: Prove will use or disclose your private health information: Prove will use or disclose your private health information: Prove will use or disclose your private health information: Prove will use or disclose your private health information: Prove will use or disclose your private health information: Prove will use or disclose your private health information: Prove will use or disclose your private health information: Prove will use or disclose your private health information provide services or support by contractual agreement Prove will be used the information provide on this form is true to the best of my knowledge. Patient/Parent or Guardian Signature Patient/Parent or Guardian Signature Date Patient/Parent or Guardian Signature	Who is the primary insured (policy holder)?				Date of Birth:				
[]	 Payment Operations (healthcare business) Appointments/reminders Business associates who provide services or support by contractual agreement Public health/law required You have the right to request a restriction of disclosure of above. Requests must be submitted in writing for review. If restriction is not granted we are required to give you a written response I have been offered and or received a copy of the Tulalip Health System Notice of Privacy Practices. https://www.tulaliphealthsystem.com/PrivacyPolicy Patient Initials Acknowledge Receipt of Notice of Privacy Practices 								
 [] For Patients Unable to Acknowledge Receipt, I hereby certify that the patient was unable to acknowledge receipt of the Notice of Privacy practices because: I certify that all the information provided on this form is true to the best of my knowledge. Patient/Parent or Guardian Signature 	Patient/Parent or Guardian Signature		Da	ate					
practices because: I certify that all the information provided on this form is true to the best of my knowledge. Patient/Parent or Guardian Signature Date	[] Authorizing Official for C.H.S.	Da	Date						
Patient/Parent or Guardian Signature Date		that the patier	nt was unable to acknowl	edge receipt of th	e Notice of Privacy				
	I certify that all the information provided on this form is true to the best of my knowledge.								
Revised 9/2018 Page 2 of 2	Patient/Parent or Guardian Signature			Date					
	Revised 9/2018				Page 2 of 2				