****For Office Use Only*** ***Mark all that apply*** Chart # _____

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

Tulalip Health System — Patient Registration

SECTION A PATIENT DEMOGRAPHIC INFORMATION

Patient Name: [LAST] [FIRST] [MIDDLE]			Patient Sex: ☐MALE ☐FEMALE
Other Names Used:	Date of Birth:	Place of Birth:	Social Security#

Address:	City:	State:	Zip Code:	County:
How long at current address?		Is this on a Reservation? ☐ Yes ☐ No		Marital Status: ☐Single ☐Married ☐Widow ☐Divorced ☐Significant Other
Home Phone#: ( ) Primary #? ☐ Yes ☐ No	Cell #: ( ) Primary #? ☐ Yes ☐ No	If yes, which Reservation?		

SECTION B PATIENT TRIBAL INFORMATION

Are you:
- ☐ Enrolled Tribal Member
- ☐ Enrollment is Pending
- ☐ Descendent of an Enrolled Member
- ☐ Prenatal Only- Paternity Affidavit on File
- ☐ Non-Native living in Tribal Household
- ☐ Non-Native

Tribe Name (if applicable):_____

Enrollment # (if applicable): _____

Blood Quantum (if known): _____

Mother's Maiden Name: [Last] [First] [Middle Initial]	Cell # ( )
Mother's Email Address:	Alternate # ( )
Father's Name: [Last] [First] [Middle Initial]	Cell # ( )
Father's Email Address:	Alternate # ( )

SECTION C EMPLOYMENT INFORMATION

Are you employed: ☐ Yes ☐No	If No, how long?	Occupation:
Employer Name:	How long with employer?	Work Phone#

Address:	City:	State:	Zip Code:

SECTION D OTHER PATIENT INFORMATION

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic/Latino ☐ Unknown by Patient ☐ Declined to Answer

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ African American ☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Unknown by Patient

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Are you a migrant worker? ☐ Yes ☐ No

Are you homeless? ☐ Yes ☐ No Where? _____

Does the patient have internet access? ☐ Yes ☐ No

Where?

☐ Home ☐ Work ☐ School ☐ Health Care Facility
☐ Library ☐ Tribe/Community Center ☐ Mobile Device

Patients Email Address: _____

☐ Home ☐ Work ☐ School ☐ Health Care Facility
☐ Library ☐ Tribe/Community Center ☐ Mobile Device

Do we have permission to send generic health information to your email address? ☐ Yes ☐ No

What is your preferred method to receive reminders? ☐ Phone ☐ Mail ☐ Email

SECTION E MILITARY SERVICE

Were you ever in any Military Service?	☐Yes	☐ No	If YES, which Branch?

****For Office Use Only*** ***Mark all that apply*** Chart # _____

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

SECTION F CONTACT INFORMATION			
Person who can be contacted in the event of an emergency:			
Name:	Relationship:		Phone#
Address:	City:	State:	Zip Code:
Next of Kin (If different from your Emergency Contact above)			
Name:	Relationship:		Phone#
Address:	City:	State:	Zip Code:

SECTION G ALTERNATE RESOURCE INFORMATION		
MEDICARE PROGRAM		
Do you currently have Medicare? ☐Yes ☐No	Medicare Number:	
Washington State MEDICAID Program		
Are you currently enrolled in WA State Medicaid Program? ☐Yes ☐No If yes, please give Medicaid Number:		
PRIVATE INSURANCE		
Private Insurance Plan? ☐Yes ☐No Plan Name:	Policy Number Group Number	
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

How we will use or disclose your private health information:

- Treatment
- 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

☐ _____ _____
Patient/Parent or Guardian Signature Date

☐ _____ _____
Authorizing Official for C.H.S. Date

☐ 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 Date